STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155472	A. BUILDING -- B. WING	06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOOSIER VILLAGE	9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/14/23 Facility Number: 000548 Provider Number: 155472 AIM Number: NA At this Emergency Preparedness survey, Hoosier Village was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 24 certified beds. At the time of the survey, the census was 5. The requirement at 42 CFR Subpart 483.73 is NOT MET as evidenced by: Quality Review conducted on 06/15/23	E 0000	Submission of this plan of correction shall not constitute or be construed as an admission that Hoosier Village Health Center provides anything other than a high quality of care to its residents. Hoosier Village considers itself to be a partner with the Indiana State Department of Health and other entities in an ongoing effort to continually improve the services provided in long term care facilities. We believe that any feedback provided to us should be taken very seriously, and we are committed to using our resources to make any adjustments necessary to achieve better outcomes for residents. As required, the facility submits the following plan of correction: Hoosier Village is requesting a desk review of the plans of corrections submitted.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	§483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):]			

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	The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October			

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	30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review, observation, and interview; the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator, the Environmental Services Director and the Administrator in Training (AIT) during record review rom 9:30 a.m. to 12:50 p.m. on 06/14/23, thirty-six month period emergency generator testing documentation for four continuous hours for the facility's emergency generator was not available for review. Based on interview at the time of record review, the Environmental Services Director stated the facility has one propane fired emergency generator and agreed supplemental load testing documentation for four hours within the most recent three year period was not available for review. Based on observations with the Administrator, the Environmental Services Director, the Maintenance Group Leader and the AIT during a tour of the facility from 1:15 p.m. to 3:10 p.m. on 06/14/23, the facility has one propane fired emergency generator located outside the building on the south side of the property.	E 0041	This deficiency was cited due to the Life Safety Code Inspector stating the facility failed to implement the emergency power system inspection, testing and maintenance requirements when the thirty-six month period emergency generator testing documentation for four continuous hours was not available for timely review. The facility provided a copy of the thirty-six month four continuous hours emergency generator testing to the Life Safety Code Inspector via telephone and picture on 6/15/2023. In addition and as directed, a copy was emailed to the Life Safety Inspector on 6/15/2023. Although documentation was provided showing proof of inspection, testing and maintenance requirements **(Attachment A),** the deficiency was still cited. The facility contacted its vendor who completes these inspections, and this inspection will occur yearly in addition to the three year requirement. The facility will place a work order	06/30/2023

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	These findings were reviewed with the Administrator, the Environmental Services Director and the AIT during the exit conference.		into the work order tracking system for the next 3 year inspections so that there will be an additional tracking system in place. To ensure ongoing compliance the tracking will be reviewed in the quarterly QAPI and Safety committee.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 06/14/23 Facility Number: 000548 Provider Number: 155472 AIM Number: NA At this Life Safety Code survey, Hoosier Village was found not in compliance with Requirements for Participation in Medicare, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original building and the nurses station near resident Room 127 and Room 128 which was constructed in 2010 were surveyed with Chapter 19 Existing Health Care Occupancies. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in support rooms and at smoke barrier and horizontal exit doors. The facility has smoke detectors hard wired to the	K 0000	Submission of this plan of correction shall not constitute or be construed as an admission that Hoosier Village Health Center provides anything other than a high quality of care to its residents. Hoosier Village considers itself to be a partner with the Indiana State Department of Health and other entities in an ongoing effort to continually improve the services provided in long term care facilities. We believe that any feedback provided to us should be taken very seriously, and we are committed to using our resources to make any adjustments necessary to achieve better outcomes for residents. As required, the facility submits the following plan of correction: Hoosier Village is requesting a desk review of the plans of corrections submitted.	

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	building's electrical system with battery back up installed in all resident sleeping rooms. The facility has a capacity of 24 and had a census of 5 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has no detached buildings providing facility services. Quality Review conducted on 06/15/23			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 10 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 10 residents, staff and visitors if needing to exit the facility from the courtyard outside the screened porch area outside the Social Center. Findings include: Based on observations with the Administrator, the Environmental Services Director, the Maintenance Group Leader and the AIT during a tour of the facility from 1:15 p.m. to 3:10 p.m. on 06/14/23, the courtyard exit gate outside the screened porch area for the Social Center could	K 0211	This deficiency was cited due to a courtyard fence being locked. The aforementioned fence is beyond 100ft of the building egress. The lock used to keep the courtyard gates secured has been removed. Staff have been educated to not place a lock on the courtyard exit gates. To monitor corrections, weekly environmental rounds **(Attachment B)** will be completed which will include the requirement to observe for locked courtyard exit gates. To ensure ongoing compliance, an audit of the weekly environmental rounds will be	07/07/2023

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	not be opened. The Social Center consisted of two exit doors marked with exit signs to exit into the screened porch area which then exited into an outdoor courtyard on the east side of the facility. The exit access for the courtyard gate was the only gate in the courtyard fence which had a hard surface walkway. Two sliding bolts were affixed to the courtyard gate which could not be moved to open the gate when the gate was tested to open multiple times. Based on interview at the time of the observations, the Environmental Services Director agreed the aforementioned means of egress was not continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. These findings were reviewed with the Administrator, the Environmental Services Director and the AIT during the exit conference. 3.1-19(b)		reviewed in the Safety committee quarterly compliance meeting for the next 6 months or until evidence of compliance is maintained. -	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, observation and interview; the facility failed to ensure documentation for the preventative maintenance of smoke detectors in all resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, National Fire Alarm and Signaling Code, 2010	K 0300	This deficiency was cited due to smoke detectors in resident rooms not being tested on a monthly basis, rather than on an annual basis. The smoke detectors are hard wired into the building's electrical system with battery backups.	07/14/2023

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	Edition, 29.10 Maintenance and Tests states fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of "Smoke Detector Test" documentation dated 02/13/23 with the Administrator, the Environmental Services Director and the Administrator in Training (AIT) during record review from 9:30 a.m. to 12:50 p.m. on 06/14/23, resident sleeping room smoke detector testing documentation for 51 weeks of the most recent 52 week period was not available for review. Based on interview at the time of record review, the Environmental Services Director stated the facility has smoke detectors hard wired to the building electrical system with battery back up installed in each resident sleeping room and stated additional weekly testing documentation was not available for review. Based on observations with the Environmental Services Director and the Maintenance Group Leader at 3:30 p.m. on 06/14/23, a Gentex Corporation Model S1209F smoke detector was installed on the ceiling in resident sleeping Room B127. Manufacturer's instructions affixed to the back of the detector stated to test the detector weekly and to keep the alarm cover clean. Based on interview at the time of the observations, the Environmental Services Director stated each resident sleeping room has the same model smoke detector installed inn the room and additional		Maintenance technicians have received education regarding the need to test smoke detectors in health center resident rooms on a monthly basis and housekeeping to ensure wiping exterior cover of the smoke alarms is done weekly. To monitor corrections, a weekly auditing log **(Attachment C)** will be completed which will include the observation to ensure the smoke detectors are in proper working order. To ensure ongoing compliance the audit logs will be reviewed in the quarterly Safety committee for the next 6 months or until compliance is determined.	

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	smoke detector testing documentation for the most recent twelve month period was not available for review. These findings were reviewed with the Administrator, the Environmental Services Director and the AIT during the exit conference. 3.1-19(b)			
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code as required by LSC Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances	K 0345	This deficiency was cited due to semi-annual fire alarm system documentation not being available for review. In addition, a heat detector in the kitchen was dated 1996 and needed to be replaced. A contract was approved and vendors had not yet replaced the heat detector at the time of the survey. A visual inspection was conducted by the facilities contracted vendor on 6/26/23. The facility contacted its vendor who complete these inspections and the contract was rewritten to include visual semi-annual inspections. The facility contacted	07/07/2023

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	e. Magnetic hold-open devices This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Alarm System Inspection" documentation dated 12/07/22 with the Administrator, the Environmental Services Director and the Administrator in Training (AIT) during record review from 9:30 a.m. to 12:50 p.m. on 06/14/23, semi-annual fire alarm system documentation six months prior to or six months after 12/07/22 was not available for review. Based on interview at the time of record review, the Environmental Services Director agreed semi-annual inspection documentation for the facility's fire alarm system was not available for review. These findings were reviewed with the Administrator, the Environmental Services Director and the AIT during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect over two staff in the kitchen. Findings include:		its vendor and the heat detector in the kitchen was replaced on 6/23/23. To ensure ongoing compliance, The facility will place a work order into the work order tracking system as a second tracking device to ensure fire alarm system inspections are completed. As well, semi annual visual inspections as well as annual test will be reviewed in each quarterly Safety committee meeting ongoing.	

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	Based on review of the "System Tests and Inspections" section of the fire alarm system inspection contractor's "Alarm System Inspection" documentation dated 12/07/22 with the Administrator, the Environmental Services Director and the Administrator in Training (AIT) during record review from 9:30 a.m. to 12:50 p.m. on 06/14/23, one of two heat detectors in the kitchen needs replaced. The "Comments" section of "Systems Tests and Inspections" section of the 12/07/22 report stated "Fixed temperature heat detector in kitchen is dated 1996 & needs replaced". Review of "Proposal for Repair/Deficiency" documentation from the fire alarm system inspection contractor indicated the proposal to replace the heat detector was approved by the facility 02/15/23. Based on interview at the time of record review, the Environmental Services Director stated the proposal was approved but the heat detector in the kitchen had not yet been replaced at the time of the survey. These findings were reviewed with the Administrator, the Environmental Services Director and the AIT during the exit conference. 3.1-19(b)			
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.			

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	9.6.1.6 Based on record review and interview, the facility failed to provide a complete written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out-of-service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Emergency Preparedness Plan: Emergency Procedure-Fire Watch" documentation dated 05/15/23 with the Administrator, the Environmental Services Director and the Administrator in Training (AIT) during record review from 9:30 a.m. to 12:50 p.m. on 06/14/23, the written fire watch policy for fire alarm system impairment did not include the statement where if the required fire alarm system is out of service for more than 4 hours in a 24-hour period the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. The written fire watch policy stated a fire watch would be conducted should the fire alarm system fail to work. Review of "Fire Watch Procedures" documentation contained in the Environmental Services Director's Life Safety record book was complete. Based on interview at the time of record review, the Administrator and the Environmental Services Director stated staff, including new hires, are trained on the "Emergency Preparedness Plan" documentation after they are hired and no less than annually and are not trained on "Fire Watch Procedures" documentation contained in the Environmental Services Director's Life Safety record book. Based on interview at the time of	K 0346	This deficiency was cited due to the facility's emergency preparedness plan lacking the specific statement "where if the required fire alarm system is out of service for more than 4 hours in a 24 hour period the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shut down until the fire alarm system has been returned to service". The facility did provide a copy of "Fire Watch Procedures" which contained all of this information. The state still cited this deficiency. In an effort to be in compliance, the facility has updated the emergency preparedness plan to include the specific language required in the fire watch section. The Fire watch procedures already contained verbiage to comply with this tag. To ensure ongoing compliance, Is reviewed and updated annually and as needed. Review is conducted with the Quarterly Safety committee meetings.	07/07/2023

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	record review, the Administrator and the Environmental Services Director agreed the fire watch documentation for fire alarm system impairment in the "Emergency Preparedness Plan" documentation was incomplete. These findings were reviewed with the Administrator, the Environmental Services Director and the AIT during the exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to ensure 2 of 10 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011	K 0353	This deficiency was cited due to 2 out of 10 sprinkler system gauges not being replaced every 5 years or documented as tested every 5 years with a calibrated gauge. In addition, 7 out of 8 of the dry pendant sprinklers on the	08/04/2023

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	Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations with the Administrator, the Environmental Services Director, the Maintenance Group Leader and the AIT during a tour of the facility from 1:15 p.m. to 3:10 p.m. on 06/14/23, the facility has supervised dry and wet sprinkler systems which had a total of ten pressure gauges. Two of the ten pressure gauges had a manufacture date of 2016 listed on the face of the sprinkler system gauge. No recalibration date information was affixed to the two sprinkler system gauges. Based on interview at the time of the observations, the Environmental Services Director stated documentation of sprinkler system gauge replacement or recalibration was not available for review for each of the two sprinkler system gauges which were more than five years old. These findings were reviewed with the Administrator, the Environmental Services Director and the AIT during the exit conference. 3.1-19(b) 2. Based on record review, observation, and interview; the facility failed to ensure 7 of 8 sprinklers in the screened porch area outside the Social Center were replaced in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire		screened in porch area were corroded. The facility contacted its vendor and the gauges and sprinklers were replaced on 6/26/23. To monitor corrections and to look for corroding and other issues, weekly environmental rounds **(Attachment C)** will be completed by maintenance staff. The facility will place a work order into the work order tracking system to track when gauges need to be replaced so there is an additional tracking system in place. To ensure ongoing compliance, the environmental logs will be reviewed in the quarterly Safety committee for the next 6 months or until compliance is determined.	

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	Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the screened porch area outside the Social Center. Findings include: Based on review of the "Deficiencies" section of the fire alarm system inspection contractor's "Sprinkler System Inspection" documentation dated 09/20/22 with the Administrator, the Environmental Services Director and the Administrator in Training (AIT) during record review from 9:30 a.m. to 12:50 p.m. on 06/14/23, dry pendant sprinklers in the porch area are corroded (green) and need to be replaced. Based on observations with the Administrator, the Environmental Services Director, the Maintenance Group Leader and the AIT during a tour of the facility from 1:15 p.m. to 3:10 p.m. on 06/14/23, seven of the eight ceiling mounted sprinklers in			

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	the screened porch area outside the Social Center were green with corrosion. Based on interview at the time of the observations, the Environmental Services Director stated one of the eight sprinklers in the screened porch area outside the Social Center was replaced after the 09/20/22 inspection but the remaining seven ceiling mounted sprinklers have not yet been replaced. These findings were reviewed with the Administrator, the Environmental Services Director and the AIT during the exit conference. 3.1-19(b)			
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed for the protection of all residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC	K 0354	This deficiency was cited due to the facility's emergency preparedness plan lacking the specific statement "where if the required sprinkler system is out of service for more than 10 hours in a 24 hour period the building shall	07/07/2023

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	9.7.5 requires sprinkler impairment procedures comply with NFPA 25. NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 15.5.2 requires nine procedures that the impairment coordinator shall follow. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Preparedness Plan: Emergency Procedure-Fire Watch" documentation dated 05/15/23 with the Administrator, the Environmental Services Director and the Administrator in Training (AIT) during record review from 9:30 a.m. to 12:50 p.m. on 06/14/23, the written fire watch policy for sprinkler system impairment did not include the statement where if the required sprinkler system is out of service for more than 10 hours in a 24-hour period the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. The written fire watch policy stated a fire watch would be conducted should the sprinkler system fail to work. Review of the "Fire Watch Procedures" documentation contained in the Environmental Services Director's Life Safety record book was complete. Based on interview at the time of record review, the Administrator and the Environmental Services Director stated staff, including new hires, are trained on the "Emergency Preparedness Plan" documentation after they are hired and no less than annually and are not trained on "Fire Watch Procedures" documentation contained in the Environmental Services Director's Life Safety record book. Based on interview at the time of record review, the		be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service". The facility did provide a copy of "Fire Watch Procedures" which contained all of this information. The state still cited this deficiency. The facility has updated the emergency preparedness plan to include the specific language required in the fire watch section. Staff have been educated on the fire watch procedures. To ensure ongoing compliance, the emergency preparedness plan is reviewed and updated annually and as needed. Review is conducted with the Quarterly Safety committee meetings.	

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	Administrator and the Environmental Services Director agreed the fire watch documentation for sprinkler system impairment in the "Emergency Preparedness Plan" documentation was incomplete. These findings were reviewed with the Administrator, the Environmental Services Director and the AIT during the exit conference. 3.1-19(b)			
K 0372 SS=D Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure openings through 1 of 1 ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where	K 0372	This deficiency was cited due to a penetration in the ceiling smoke barrier in the employee break room. The smoke barrier was repaired immediately on the same day as the life safety survey. The smoke barrier has been thoroughly inspected and no further gaps or penetrations have been identified.	06/30/2023

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	a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect over two staff and visitors in the Staff Lounge by the service hall. Findings include: Based on observations with the Administrator, the Environmental Services Director, the Maintenance Group Leader and the AIT during a tour of the facility from 1:15 p.m. to 3:10 p.m. on 06/14/23, a four inch by four inch hole was noted in the ceiling of the Staff Lounge near the center of the room. The ceiling consisted of two layers of 5/8th's inch thick drywall. Based on interview at the time of the observations, the Environmental Services Director stated it appeared the hole was where a ceiling mounted fire alarm system smoke detector had been, the smoke detector was moved because it was too close to an HVAC vent and agreed the aforementioned opening did not ensure the ceiling smoke barrier was protected to maintain the fire resistance rating of the smoke barrier. These findings were reviewed with the Administrator, the Environmental Services Director and the AIT during the exit conference. 3.1-19(b)		Maintenance technicians responsible for completing electrical or plumbing related work orders have been educated to ensure that any pipes, wires, or devices moved that pass through a smoke or fire barrier have been treated with flame caulk to protect the barrier from smoke or fire passage during a real fire event. As a means of ongoing compliance the DES will continue visual inspection of the building and report findings to the safety committee quarterly ongoing	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected			

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	and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to document activation of the fire alarm system second shift fire drills conducted between 6:00 a.m. and 9:00 p.m. for 1 of 4 quarters. LSC 19.7.1.4 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Report" documentation with the Administrator, the Environmental Services Director and the Administrator in Training (AIT) during record review from 9:30 a.m. to 12:50 p.m. on 06/14/23, documentation for the second shift fire drill conducted on 01/20/23 at 8:00 p.m. indicated the drill was conducted after 6:00 a.m. but before 9:00 p.m. and did not include activation of the fire alarm system and transmission of the fire alarm signal at the time of the fire drill. The aforementioned second shift fire drill documentation stated "Silent" in response to "Fire Alarm Activation Method" and "NA" in response to "Monitoring company received signal	K 0712	This deficiency was cited due to the fire alarm system not being activated for a fire drill conducted prior to 9pm. Maintenance staff in charge of conducting these drills have been educated regarding the Emergency Drills policy which state fire drills must be conducted with an audible alarm for all drills not occurring between 9pm and 6am. In order to monitor for corrections, a drill log **(Attachment D)** will be kept in the binder where drills are filed, which shows all of the drills for the year so that times of drills can be easily viewed for scheduling purposes. In addition, a sign will be added to the front of fire drills binder reminding staff that live audible drills must occur outside of the 9pm to 6am window.	07/07/2023

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	at". Based on interview at the time of record review, the Environmental Services Director stated the facility operates three shifts per day and agreed documentation for the aforementioned second shift fire drill conducted after 6:00 a.m. but before 9:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal at the time of the fire drill. These findings were reviewed with the Administrator, the Environmental Services Director and the AIT during the exit conference. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder			

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	circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review, observation and interview; the facility failed to document 36 month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff and visitors. Findings include:	K 0918	This deficiency was cited due to the Life Safety Code Inspector stating the facility failed to implement the emergency power system inspection, testing and maintenance requirements when the thirty-six month period emergency generator testing documentation for four continuous hours was not available for timely review. The facility provided a copy of the thirty-six month four continuous hours emergency generator testing to the Life Safety Code Inspector via telephone and picture on 6/15/2023. In addition and as directed, a copy was emailed to the Life Safety Code Program Supervisor on 6/15/2023. Although documentation was provided showing proof of inspection, testing and maintenance requirements **(Attachment A),** the deficiency was still cited. The facility contacted its vendor who completes these inspections,	07/08/2023

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	Based on record review with the Administrator, the Environmental Services Director and the Administrator in Training (AIT) during record review from 9:30 a.m. to 12:50 p.m. on 06/14/23, thirty-six month period emergency generator testing documentation for four continuous hours for the facility's emergency generator was not available for review. Based on interview at the time of record review, the Environmental Services Director stated the facility has one propane fired emergency generator and agreed supplemental load testing documentation for four hours within the most recent three year period was not available for review. Based on observations with the Administrator, the Environmental Services Director, the Maintenance Group Leader and the AIT during a tour of the facility from 1:15 p.m. to 3:10 p.m. on 06/14/23, the facility has one propane fired emergency generator located outside the building on the south side of the property. These findings were reviewed with the Administrator, the Environmental Services Director and the AIT during the exit conference. 3.1-19(b)		and this inspection will occur yearly in addition to the three year requirement. The facility will place a work order into the work order tracking system for the next 3 year inspections so that there will be an additional tracking system in place. To ensure ongoing compliance the tracking will be reviewed in the quarterly QAPI and Safety committee.	