STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155217	A. BUILDING -- B. WING	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGBURG, THE	1712 LELAND DR HUNTINGBURG, IN 47542

(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: 10/15/24 Facility Number: 000122 Provider Number: 155217 AIM Number: 100290560 At this Emergency Preparedness survey, The Waters of Huntingburg was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 95 certified beds. At the time of the survey, the census was 44. Quality Review completed on 10/16/24 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review 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). 1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator	E 0041	**E041**– It is the intent of the facility to ensure emergency generator is provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as nurses' station and to maintain a complete written record of monthly generator load testing for	10/28/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rebecca Brown	ADM, HFA	10/29/2024

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	was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' stations. NFPA 99, 2012 Edition, Health Care Facilities Code, at 6.4.1.1.17 requires a remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate: a. When the emergency or auxiliary power source is operating to supply power to load. b. When the battery charger is malfunctioning. (2) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: a. Low lubricating oil pressure. b. Low water temperature. c. Excessive water temperature. d. Low fuel when the main fuel storage tank contains less than a 4-hour operating supply. e. Overcrank (failed to start). f. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 6.4.1.1.17(1) and (2) occur but need not display these conditions individually. This deficient practice could affect all residents, as well as visitors and staff in the facility. Findings include: Based on observation on 10/15/24 between 11:30 a.m. and 2:00 p.m. during a tour of the facility with		generator during all 12 months of the year to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 10/28/2024 the facilities licensed generator contractor relocated the alarm annunciator to the occupied unit 1 nurses' station to meet set standards. The Administrator verified the work 10/28/2024. b On 10/23/2024 the Maintenance Supervisor conducted the monthly load testing of the generator and documented the results in the facilities life safety binder to meet set standards. The Administrator verified the work 10/28/24 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 10/28/2024 the Administrator inserviced the Maintenance Supervisor/designee on the requirement to ensure the generator alarm annunciator is located in a location readily observed by operating personnel and to ensure monthly generator load testing is being completed and documented in the life safety binder to meet set standards. b The Maintenance Supervisor /designee will ensure the	

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	the Administrator and Administrator-in-Training (AIT), the remote generator annunciator panel was located at the Unit 2 Nurse's Station which was not currently in operation. When asked, the Administrator said Unit 2 is currently closed due to a low census. There are no residents currently on Unit 2 and the nearest Nurse's Station is located on the Memory Care, which was down a long corridor and on the other side of a set of smoke barrier doors. The generator annunciator panel would not be heard or seen from the Memory Care Nurse's Station if activated. This finding was reviewed with the Administrator and AIT during the exit conference. 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 5 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 10/15/24 between 9:00 a.m. and 11:30 a.m. with the Administrator and Administrator-in-Training (AIT) present, there was no documentation on the generator monthly load test log for amperage readings from May to September 2024. Based on interview at the time of		generator alarm annunciator is located in a location readily observed by operating personnel and will ensure monthly generator load testing is being completed and documented in the facilities life safety binder to meet set standards. c The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The Administrator will present the inspection/testing results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. Results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10/28/2024.**	

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	record review, the Administrator confirmed there were no amperage readings on the monthly generator log between May and September 2024. This finding was reviewed with the Administrator and AIT during the exit conference.			
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 483.90(a) in conjunction with the Investigation of Complaint #IN00443883. Survey Date: 10/15/24 Facility Number: 000122 Provider Number: 155217 AIM Number: 100290560 At this Life Safety Code survey, The Waters of Huntingburg was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 95 and had a census of 45 at the time of this survey.	K 0000	Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.	

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	All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered, except two wood sheds and one metal shed outside the southwest exit used for facility storage. Quality Review completed on 10/16/24			
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to ensure the cook top for 1 of 1 stove/oven in the Physical Therapy area was shut off at the switch when not in use. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. (c) The switch is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. This deficient practice could affect at least 5	K 0324	**K324**– It is the intent of the facility to ensure the cook top for stove/oven in the physical therapy area is shut off at the switch when not in use to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On 10/28/2024 the electrician/maintenance supervisor/designee installed a lockable disconnect switch to the stove/oven in the physical therapy to meet set standards. The Administrator verified the work on 10/28/2024 . **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. **3. MEASURES TO PREVENT REOCCURRENCE**: a. The Administrator inserviced the Maintenance Supervisor / Physical Therapy Director on 10/28/2024 on the requirement to ensure the cook top for stove/oven in the physical therapy area is shut off and locked out at the disconnect	10/28/2024

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	resident, staff and visitors while in the Physical Therapy area. Findings include: Based on observations on 10/15/24 between 11:30 a.m. and 2:00 p.m. during a tour of the facility with the Administrator and Administrator-in-Training (AIT), there was a cooktop stove/oven in the Physical Therapy area. The stove/oven was not being used at the time of observation and the power to the stove/oven was on. Based on interview at the time of observation, the Administrator confirmed the cooktop stove/oven was not deactivated when not in use, and further confirmed the stove/oven in the Physical Therapy area was not equipped with a disconnect switch with a timer so Physical Therapy staff could shut the power off to the stove/oven when not in use. This finding was reviewed with the Administrator and AIT during the exit conference. 3.1-19(b)		switch when not in use to meet set standards. b. The Maintenance Supervisor / Physical Therapy Director will ensure the cook top for stove/oven in the physical therapy area is shut off and locked out at the disconnect switch when not in use as a part of the facility's weekly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The monitoring results will be presented by the Administrator at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible**	

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			allegation of compliance with all regulatory requirements. Our date of compliance is 10/28/2024.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 dry sprinkler system during 32 of the past 52 weeks for the sprinkler system's pressure gauges, and during 8 of the past 12 months for the sprinkler system's control valves. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: a. Based on record review on 10/15/24 between 9:00 a.m. and 11:30 a.m. with the Administrator and Administrator-in-Training (AIT) present, there was no documentation available to show the	K 0353	**K353** – It is the intent of the facility to ensure to document sprinkler system inspections in accordance with NFPA 25 for dry sprinkler system and for the sprinkler system's control valves to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 10/28/2024 the Maintenance supervisor conducted the weekly inspection of the dry sprinkler system gauges and documented the results in the facilities life safety binder to meet set standards. The Administrator verified the work on 10/28/2024 . 2.On 10/28/2024 the Maintenance Supervisor conducted the monthly sprinkler system control valves inspection and documented the results in the facilities life safety binder to meet set standards. The Administrator verified the work on 10/28/2024 . **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**:	10/28/2024

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	facility's dry sprinkler system gauges were inspected weekly during 32 of the past 52 week period. The only weekly sprinkler gauge inspections were for the weeks between May 13 and October 2 of 2024. Based on interview at the time of record review, the Administrator confirmed there was no documentation available to show that the facility's sprinkler gauges had been inspected at least weekly during 32 of the past 52 weeks. Based on observations on 10/15/24 between 11:30 a.m. and 2:00 p.m. during a tour of the facility with the Administrator and AIT the facility had three pressure gauges at the sprinkler riser. b. Based on record review on 10/15/24 between 9:00 a.m. and 11:30 a.m. with the Administrator and Administrator-in-Training (AIT) present, there was no monthly sprinkler system control valves inspection documentation for 8 of the past 12 months. The only monthly inspections available were for June, July, August, and October of 2024. Based on interview at the time of record review, the Administrator confirmed the lack of sprinkler system inspections on the control valves during 8 the past 12 months. This finding was reviewed with the Administrator and AIT during the exit conference. 3.1-19(b)		1.On 10/28/2024 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure the weekly dry sprinkler system gauges inspection and the monthly sprinkler system control valves inspection is conducted and documented to meet set standards. 2.Maintenance Supervisor/designee will ensure the weekly dry sprinkler system gauges inspection and the monthly sprinkler system control valves inspection is conducted and documented as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly	

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			Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10/28/2024.**	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to ensure 2 of 12 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 10/15/24 between 9:00 a.m. and 11:30 a.m. with the Administrator and Administrator-in-Training (AIT) present, fire drill reports dated 05/07/24 at 7:00 p.m. and 06/06/24 at 1:30 p.m., were not provided with adequate documentation for the transmission of the alarm to the monitoring company. Only the date of the fire drill was	K 0712	**K712** –It is the intent of the facility to ensure fire drill reports include complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 10/28/2024 the Maintenance Supervisor conducted fire drills and recorded the time the monitoring company received the transmission of the fire alarms to meet set standards. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were.	10/28/2024

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	provided, not the time the monitoring company received the transmission of the fire alarm. Based on interview at the time of record review, the Administrator confirmed there was not adequate information included with 2 of 12 fire drill reports to verify that transmission of the alarm was received by the monitoring company. This finding was reviewed with the Administrator and AIT during the exit conference. 3-1.19(b) 3.1-51(c)		3 **MEASURES TO PREVENT REOCCURRENCE**: a Administrator inserviced Maintenance Supervisor/designee on 10/28/2024 to ensure fire drills are conducted and include on the fire drill documentation sheet the recording of the time the monitoring company received the transmission of the fire alarm as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. b The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The fire drill documentation will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction	

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			developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10/28/2024.**	
K 0761 SS=F Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on record review, observation and interview, the facility failed to maintain 1 of 1 rolling fire door in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80 5.2.1 requires fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. This deficient practice could affect all occupants while in the dining room. Findings include: Based on record review on 10/15/24 between 9:00 a.m. and 11:30 a.m. with the Administrator and Administrator-in-Training (AIT) present, there was no annual rolling fire door inspection to review. The only reference to the kitchen rolling fire door between the kitchen and dining room	K 0761	**K761** – It is the intent of the facility to ensure to maintain rolling fire doors in accordance with NFPA 80, Standard for Fire Doors and Other opening protectives, 2010 edition to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 10/23/2024 the facilities licensed fire protection company conducted the annual rolling fire door inspection and documented the information in the life safety binder to meet set standards. The Administrator verified the work on 10/23/2024 . 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 10/28/2024 the Administrator inserviced the maintenance Supervisor on the	10/28/2024

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(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
	was on the fire alarm system inspection report dated 01/18/24 which stated in the remarks section "Kitchen Roll Door Release Box did not activate on Alarm." Based on interview during record review, the Administrator said this was the only report available that included information about the kitchen rolling fire door, but agreed the report only addressed the roll door release box and not the entire fire roll door assembly. Furthermore, the Administrator said the roll door release box still does not release the rolling metal door when the fire alarm system is activated, but the kitchen staff has been instructed to manually close the door in the event the fire alarm system is activated. This was confirmed by the kitchen manager during a tour of the kitchen between 11:30 a.m. and 2:00 p.m. This finding was reviewed with the Administrator and AIT during the exit conference. 3.1-19(b)		annual inspecting and testing of the rolldown door assemblies to meet set standards. b Maintenance Supervisor/designee will ensure the annual inspection and testing of fire door assemblies is conducted as a part of the facility's annual Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155217	A. BUILDING 01 B. WING	10/15/2024

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			This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10/28/2024.	
K 0916 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' stations. NFPA 99, 2012 Edition, Health Care Facilities Code, at 6.4.1.1.17 requires a remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate: a. When the emergency or auxiliary power source is operating to supply power to load. b. When the battery charger is malfunctioning. (2) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: a. Low lubricating oil pressure. b. Low water temperature. c. Excessive water temperature. d. Low fuel when the main fuel storage tank contains less than a 4-hour operating supply. e. Overcrank (failed to start). f. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established	K 0916	K0916– It is the intent of the facility to ensure emergency generator is provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as nurses' station and to maintain a complete written record of monthly generator load testing for generator during all 12 months of the year to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 10/28/2024 the facilities licensed generator contractor relocated the alarm annunciator to the occupied unit 1 nurses' station to meet set standards. The Administrator verified the work 10/28/2024. b On 10/23/2024 the Maintenance Supervisor conducted the monthly load testing of the generator and documented the results in the facilities life safety binder to meet set standards. The Administrator verified the work 10/28/24 2 **ALL OTHERS WITH**	10/28/2024

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	at a continuously monitored location. This derangement signal shall activate when any of the conditions in 6.4.1.1.17(1) and (2) occur but need not display these conditions individually. This deficient practice could affect all residents, as well as visitors and staff in the facility. Findings include: Based on observation on 10/15/24 between 11:30 a.m. and 2:00 p.m. during a tour of the facility with the Administrator and Administrator-in-Training (AIT), the remote generator annunciator panel was located at the Unit 2 Nurse's Station which was not currently in operation. When asked, the Administrator said Unit 2 is currently closed due to a low census. There are no residents currently on Unit 2 and the nearest Nurse's Station is located on the Memory Care, which was down a long corridor and on the other side of a set of smoke barrier doors. The generator annunciator panel would not be heard or seen from the Memory Care Nurse's Station if activated. This finding was reviewed with the Administrator and AIT during the exit conference. 3.1-19(b)		**POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 10/28/2024 the Administrator inserviced the Maintenance Supervisor/designee on the requirement to ensure the generator alarm annunciator is located in a location readily observed by operating personnel and to ensure monthly generator load testing is being completed and documented in the life safety binder to meet set standards. b The Maintenance Supervisor /designee will ensure the generator alarm annunciator is located in a location readily observed by operating personnel and will ensure monthly generator load testing is being completed and documented in the facilities life safety binder to meet set standards. c The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The Administrator will present the inspection/testing results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. Results and system components will be reviewed by	

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			the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10/28/2024.**	
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 5 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 10/15/24 between 9:00 a.m. and 11:30 a.m. with the Administrator and Administrator-in-Training (AIT) present, there was no documentation on the generator monthly load test log for amperage readings from May to September 2024. Based on interview at the time of record review, the Administrator confirmed there	K 0918	**K918** – It is the intent of the facility to ensure to maintain a complete written record of monthly generator load testing for the generator to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 10/28/2024 the Maintenance Supervisor/designee conducted the load testing of the emergency generator and recorded the amperage readings and documented the results in the facilities life safety binder to meet set standards. The Administrator verified the work on 10/28/2024. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a The Administrator inserviced	10/28/2024

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	were no amperage readings on the monthly generator log between May and September 2024. This finding was reviewed with the Administrator and AIT during the exit conference. 3.1-19(b)		the Maintenance Supervisor/designee on 10/28/2024 the requirement to ensure a load bank test is conducted on the emergency generator including the amperage readings and documented in the life safety binder to meet set standards. b The Maintenance Supervisor/designee will ensure a load bank test is conducted on the emergency generator including the amperage readings and documented in the life safety binder as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance	

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			Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10/28/2024.**	