STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING -- B. WING	04/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RETREAT AT THE STRATFORD, THE	2460 GLEBE ST CARMEL, IN 46032

(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: 04/04/23 Facility Number: 011151 Provider Number: 155794 AIM Number: NA At this Emergency Preparedness survey, The Retreat at the Stratford was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 18 certified beds. At the time of the survey, the census was 11. Quality Review completed on 04/11/23	E 0000	This Plan of Correction represents The Retreat at the Stratford allegation of compliance. Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	
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. §483.73(e), §485.625(e) (e) Emergency and standby power systems.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lorna Ray	Care Services Administrator	05/06/2023

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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	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):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the			

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	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 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013.			

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	(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 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 records review and interview with the Maintenance Technician and Care Services Administrator on 04/04/23 between 9:45 a.m. and 12:15 p.m., no documentation of an annual fuel quality test for the diesel generator was available for review. The facility has 1 diesel fired generator. Based on interview at the time of records review, the fuel quality testing for the diesel fired generator could not be located. Based on records review and interview with the Maintenance Technician and Care Services Administrator on 04/04/23 between 9:45 a.m. and 12:15 p.m., prior 03/22 no documentation was available for review to show the diesel generator set in service was exercised at least once monthly, for a minimum of 30 minutes. The only monthly load test documentation provided reflected tests for March and April of 2023. The Maintenance Technician stated the monthly generator tests prior to 3/23 were conducted by the prior Maintenance Supervisor and did not know where the documentation was located.	E 0041	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Generator annual fuel quality test will be conducted. Generator will have monthly 30 minute load test completed. Generator will have three-year 4 hour test completed. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. No further concerns noted. Facilities team will be educated on generator testing requirements. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: Director of Facilities or designee will conduct monthly generator testing audits. Any issues identified will require a work order placed for repair. All logs will be audited monthly. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what	06/02/2023

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	Based on records review and interview with the Maintenance Technician and Care Services Administrator on 04/04/23 between 9:45 a.m. and 12:15 p.m., the facility provided documentation for testing of the emergency generator, however, could not provide documentation of a three-year 4-hour test. This finding was acknowledged by the Maintenance Technician at the time of discovery and again at the exit conference with the Maintenance Technician and Care Services Administrator present.		quality assurance program will be put into place The Director of Facilities or designee will bring audits to monthly QAPI Committee for review and recommendation until 100% compliance is met. Any recommendation made by the committee will be followed up by the Director of Facilities or designee.	
K 0000 Bldg. 02	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). Survey Date: 04/04/23 Facility Number: 011151 Provider Number: 155794 AIM Number: NA At this Life Safety Code survey, The Retreat at the Stratford was found not in compliance with Requirements for Participation in Medicare, 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 facility located on the second floor of a three-story building was determined to be of Type II (111) construction and fully sprinkled. The	K 0000	This Plan of Correction represents The Retreat at the Stratford allegation of compliance. Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	

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	facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard-wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 18 and had a census of 11 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 04/11/23			
K 0222 SS=F Bldg. 02	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be			

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	electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and Interview, the facility failed to ensure 1 of 2 delayed egress locking	K 0222	What corrective actions will be accomplished for those residents	06/02/2023

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	arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect all residents. Findings include: Based on observation and interview during a facility tour with the Maintenance Technician and Care Services Administrator on 04/04/23 between 12:15 p.m. and 2:30 p.m., the double door set between the Skilled nursing and Assisted Living section on the 2nd floor, were equipped with a 15 second delayed egress. When the exit doors were tested the irreversible process to release the lock was not initiated. Based on interview at the time of observation, the Maintenance Technician tried 3 times to activate the delay egress and stated the delayed egress is not working and will need to be repaired. This finding was acknowledged by the Maintenance Technician at the time of discovery and again at the exit conference with the Maintenance Technician and Care Services		found to have been affected by the deficient practice: The Director of Facilities or designees will ensure door with delayed egress locks is operational. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. Director of Facilities or designee will audit exit doors with delayed egress locks on Skilled Unit to ensure all doors are operational. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: Director of Facilities or designee will audit exit door with delayed egress locks. The Director of Facilities will identify any issues and create work order for repair. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place The Director of Facilities or designee will bring the results of the audits to the monthly QAPI Committee for review and recommendation. Any recommendation made by the committee will be followed up by	

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	Administrator present. 3.1-19(b)		the Director of Facilities or designee and the results will be brought to the next scheduled QAPI committee meeting. This practice will continue for a minimum of 3 months or longer if a pattern of non-compliance is shown.	
K 0321 SS=E Bldg. 02	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons)			

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	f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 5 residents, as well as staff and visitors in the vicinity of the Laundry. Findings include: Based on observation and interview during a facility tour with the Maintenance Technician and Care Services Administrator on 04/04/23 between 12:15 p.m. and 2:30 p.m., the laundry area corridor door, equipped with a self-closing device, failed to self-close and latch into the door frame. This finding was acknowledged by the Maintenance Technician at the time of discovery and again at the exit conference with the Maintenance Technician and Care Services Administrator present. 3.1-19(b)	K 0321	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The Director of Facilities or designees will ensure laundry door equipped with a self-closing device will latch to door frame by June 2, 2023 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. Director of Facilities or designee will audit exit doors with delayed egress locks on Skilled Unit to ensure all doors are operational. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: The Director of Facilities will train all staff, in the proper regulations regarding the need for egress doors to self-close, and latch. The management team will audit doors daily, quickly identify and correct areas of concern. If the deficiency is found to be a mechanical issue ie. the door does not latch to the frame, a workorder will	06/02/2023

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			immediately be requested via the concierge. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place The Director of Facilities or designee will bring the workorders will be brought to the next scheduled QAPI committee meeting. This practice will continue for a minimum of 3 months or longer if a pattern of non-compliance is shown.	
K 0345 SS=C Bldg. 02	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 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 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:	K 0345	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The Director of Facilities or designees will ensure visual semi-annual inspection of fire alarm system is conducted. How the facility will identify other residents having the potential to	06/02/2023

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	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 e. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: Based on records review and interview with the Maintenance Technician and Care Services Administrator on 04/04/23 between 9:45 a.m. and 12:15 p.m., no documentation could be provided regarding a visual semi-annual fire alarm system inspection 6 months prior to the Annual inspection dated 03/08/23. During the survey the Maintenance Technician searched for the missing documentation but was unable to locate any further documentation. This finding was acknowledged by the Maintenance Technician at the time of discovery and again at the exit conference with the Maintenance Technician and Care Services Administrator present. 3.1-19(b)		be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. No further concerns were noted. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: Director of Facilities or designee will audit inspections twice a year (6 months apart) to ensure semi-annual inspection is completed. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place The Director of Facilities or designee will bring the results of the audits to the monthly QAPI Committee for review and recommendation. Any recommendation made by the committee will be followed up by the Director of Facilities or designee and the results will be brought to the next scheduled QAPI committee meeting. This practice will continue for a minimum of 3 months or longer if a pattern of non-compliance is shown.	
K 0351 SS=F	NFPA 101 Sprinkler System - Installation			

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	155794	A. BUILDING 02 B. WING	04/04/2023

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RETREAT AT THE STRATFORD, THE	2460 GLEBE ST CARMEL, IN 46032

(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
Bldg. 02	Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) 1. Based on observation and interview, the facility failed to provide automatic extinguishing protection for 1 of 1 elevator machine rooms servicing the second-floor residents. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon, or prior to, the application of water from the sprinkler located in the elevator machine room. NFPA 101, Section 9.7.3.1 states in any occupancy where the character of the potential fuel for fire is such that extinguishment or control of fire is effectively accomplished by a type of automatic extinguishing system other than an automatic sprinkler system, such as water mist, carbon	K 0351	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Facility will schedule installation of automatic sprinkler in elevator room. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. Installation of sprinkler head will be installed in elevator room that services Skilled Nursing Department	06/10/2023

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	dioxide, dry chemical, foam, Halon 1301, water spray, or a standard extinguishing system of another type, that system shall be permitted to be installed in lieu of an automatic sprinkler system. Such systems shall be installed, inspected, and maintained in accordance with appropriate NFPA standards. Section 9.7.3.2 states, if the extinguishing system is installed in lieu of a required, supervised automatic sprinkler system, the activation of the extinguishing system shall activate the building fire alarm system. This deficient practice could affect all residents, staff and visitors using the skilled nursing elevator. Findings include: Based on observation and interview during a facility tour with the Maintenance Technician and Care Services Administrator on 04/04/23 between 12:15 p.m. and 2:30 p.m., the elevator equipment room in the basement adjacent to elevator #1 which services the residents of the second-floor skilled nursing section of the facility, was not provided with automatic extinguishing protection. Based on interview at the time of observation, the Maintenance Technician acknowledged the aforementioned elevator equipment room was not provided with automatic extinguishing protection. This finding was acknowledged by the Maintenance Technician at the time of discovery and again at the exit conference with the Maintenance Technician and Care Services Administrator present. 2. Based on observation and interview, the facility failed to ensure the installation of the sprinkler system met the requirements of NFPA 13. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition; Section 6.2.9.1 states a supply of at least six spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have operated or been		What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: Director of facilities will add sprinkler head to inspection conducted every 6 months. Audit will be completed to ensure inspection is completed. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place. The Director of Facilities or designee will bring the results of the audits to the monthly QAPI Committee for review and recommendation. Any recommendation made by the committee will be followed up by the Director of Facilities or designee and the results will be brought to the next scheduled QAPI committee meeting. This practice will continue for until a pattern of non-compliance is shown.	

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	damaged in any way can be promptly replaced. This deficient practice could affect all occupants within the facility. Findings include: Based on observation and interview during a facility tour with the Maintenance Technician and Care Services Administrator on 04/04/23 between 12:15 p.m. and 2:30 p.m., the sprinkler riser room contained 2 spare sprinkler boxes that 1 of which contained 4 spare sprinklers which were loose and unsecured. This finding was acknowledged by the Maintenance Technician at the time of discovery and again at the exit conference with the Maintenance Technician and Care Services Administrator present. 3.1-19(b)			
K 0353 SS=F Bldg. 02	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			

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	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 record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the quarterly sprinkler system inspection records with the Maintenance Technician and Care Services Administrator on 04/04/23 between 9:45 a.m. and 12:15 p.m., 1 of 4 quarterly sprinkler reports was missing. Reports	K 0353	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The Director of Facilities or designees will ensure sprinkler system inspections are conducted quarterly. Facilities team will be educated on sprinkler system inspections. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. Facilities team will schedule inspections of sprinkler systems to be conducted every 6 months. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: Director of Facilities or designee will audit inspections twice a year (6 months apart) to ensure semi-annual inspection is completed. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place The Director of Facilities or	06/02/2023

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	were provided for 3 quarters dated, 8/22/22, 12/29/22 and 3/8/23. During an interview at the time of record review, the Maintenance Technician acknowledged there was no written documentation available to show the sprinkler system had been inspected for all 4 quarters of the previous year. This finding was acknowledged by the Maintenance Technician at the time of discovery and again at the exit conference with the Maintenance Technician and Care Services Administrator present. 2. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly, or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Technician and Care Services Administrator on 04/04/23 between 9:45 a.m. and 12:15 p.m., there was no monthly inspection of the wet pipe sprinkler system's gauges and valves		designee will bring the results of the audits to the monthly QAPI Committee for review and recommendation. Any recommendation made by the committee will be followed up by the Director of Facilities or designee and the results will be brought to the next scheduled QAPI committee meeting. This practice will continue for a minimum of 3 months or longer if a pattern of non-compliance is shown.	

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	other than for 1 month dated 06/15/22. All other monthly checks on the report entitled "Monthly Inspection of Wet Pipe Sprinkler System" were blank. This finding was acknowledged by the Maintenance Technician at the time of discovery and again at the exit conference with the Maintenance Technician and Care Services Administrator present. 3.1-19(b)			
K 0355 SS=F Bldg. 02	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure all portable fire extinguishers were given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that	K 0355	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The Director of Facilities or designee will schedule annual inspection of fire extinguishers. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. No further concerns were noted. What measures will be put in place or what systemic changes the facility will makes to ensure	06/02/2023

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	indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect all residents. Findings include: Based on observation and interview during a facility tour with the Maintenance Technician and Care Services Administrator on 04/04/23 between 12:15 p.m. and 2:30 p.m., the annual inspection tag on the ABC fire extinguisher located in the 200-hall corridor lacked documentation of a current annual inspection tag. The most recent annual inspection tag for the fire extinguishers throughout the facility was dated 03/22. The Maintenance Technician stated that the 2nd floor fire extinguisher was consistent with the other extinguishers throughout the facility and had not been inspected annually since 03/22. This finding was acknowledged by the Maintenance Technician at the time of discovery and again at the exit conference with the Maintenance Technician and Care Services Administrator present. 3.1-19(b)		that the deficient practice does not occur: Director of Facilities or designee will audit fire extinguisher monthly and will schedule yearly maintenance How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place The Director of Facilities or designee will bring the results of the audits to the monthly QAPI Committee for review and recommendation. Any recommendation made by the committee will be followed up by the Director of Facilities or designee and the results will be brought to the next scheduled QAPI committee meeting. This practice will continue for a minimum of 3 months or longer if a pattern of non-compliance is shown.	
K 0363 SS=E Bldg. 02	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke			

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	compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 2 residents. Findings include:	K 0363	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The Director of Facilities or designee will repair door handle on room 266 to ensure that it closes	06/02/2023

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	Based on observation and interview during a facility tour with the Maintenance Technician and Care Services Administrator on 04/04/23 between 12:15 p.m. and 2:30 p.m., the corridor door to Resident Room 266 failed to close and latch positively into the door frame. Based on interview at the time of the observations, the Maintenance Technician agreed the aforementioned corridor door did not close and latch into the door frame and would not resist the passage of smoke. This finding was acknowledged by the Maintenance Technician at the time of discovery and again at the exit conference with the Maintenance Technician and Care Services Administrator present. 3.1-19(b)		and latches positively to the door frame. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. No further concerns were noted. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: Director of Facilities will train all staff, in the proper regulations regarding the need for egress doors to self close, and latch. Management team will audit doors daily, quickly identify and correct areas of concern. If the deficiency is found to be a mechanical issue ie. the door does not latch to the frame, a workorder will immediately be requested via the concierge. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place The Director of Facilities or designee Workorders will be brought to the next scheduled QAPI committee meeting. This practice will continue for a minimum of 3 months or longer if a pattern of non-compliance is	

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			shown.	
K 0372 SS=E Bldg. 02	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 the penetrations caused by the passage of wire and/or conduit through 1 of 2 smoke barriers walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of	K 0372	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The Director of Facilities or designee will seal penetrations in smoke barrier wall above the drop ceiling near the Salon door exit doors. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. No further concerns were noted. What measures will be put in place or what systemic changes the facility will makes to ensure	06/02/2023

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	restricting the movement of smoke. This deficient practice could affect staff and at least 10 residents. Findings include: Based on observation and interview during a facility tour with the Maintenance Technician and Care Services Administrator on 04/04/23 between 12:15 p.m. and 2:30 p.m., two unsealed penetrations were discovered in the smoke barrier wall above the drop ceiling near the Salon door exit doors. This finding was acknowledged by the Maintenance Technician at the time of discovery and again at the exit conference with the Maintenance Technician and Care Services Administrator present. 3.1-19(b)		that the deficient practice does not occur: Director of Facilities or designee will audit barrier walls quarterly to ensure compliance. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place The Director of Facilities or designee will bring the results of the audits to the monthly QAPI Committee for review and recommendation. Any recommendation made by the committee will be followed up by the Director of Facilities or designee and the results will be brought to the next scheduled QAPI committee meeting. This practice will continue for a minimum of 3 months or longer if a pattern of non-compliance is shown.	
K 0511 SS=E Bldg. 02	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of over 5 wet locations were provided with ground fault circuit interrupter	K 0511	What corrective actions will be accomplished for those residents found to have been affected by the	06/02/2023

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	(GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where		deficient practice: The Director of Facilities or designee will replace outlet what is located within 1 foot of sink with a GFCI protected outlet. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. No further concerns were noted. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: Director of Facilities or designee will audit all GFCI outlets to ensure compliance. Director of Facilities or designee will audit GFCI protected outlets quarterly to ensure compliance. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place The Director of Facilities or designee will bring the results of the audits to the monthly QAPI Committee for review and recommendation. Any recommendation made by the committee will be followed up by the Director of Facilities or designee and the results will be brought to the next scheduled	

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	155794	A. BUILDING 02 B. WING	04/04/2023

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	removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff and up to 4 residents while in the Pantry area. Findings include: Based on observation and interview during a facility tour with the Maintenance Technician and Care Services Administrator on 04/04/23 between 12:15 p.m. and 2:30 p.m., the Pantry area had 2 sinks. The outlet located within 1 foot of the small sink was not GFCI protected. When tested, the aforementioned receptacle did not trip indicating the outlet was on a GFCI circuit. The Maintenance Technician at the time of observation stated he did not believe the receptacle was on a GFCI circuit. This finding was acknowledged by the Maintenance Technician at the time of discovery and again at the exit conference with the		QAPI committee meeting. This practice will continue for a minimum of 3 months or longer if a pattern of non-compliance is shown.	

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	Maintenance Technician and Care Services Administrator present. 3.1-19(b)			
K 0712 SS=F Bldg. 02	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 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 1. Based on record review and interview, the facility failed to conduct fire drills on each shift for 2 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on records review and interview with the Maintenance Technician and Care Services Administrator on 04/04/23 between 9:45 a.m. and 12:15 p.m., the following shifts were missing documentation of a completed fire drill: a) A Third shift fire drill in the First quarter of 2023. b) A Third shift fire drill in the Fourth quarter of	K 0712	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The facilities team was educated on Fire Drill policy and procedure. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. No further concerns were noted. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not	06/02/2023

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	2022. This finding was acknowledged by the Maintenance Technician at the time of discovery and again at the exit conference with the Maintenance Technician and Care Services Administrator present. 2. Based on record review and interview, the facility failed to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on records review and interview with the Maintenance Technician and Care Services Administrator on 04/04/23 between 9:45 a.m. and 12:15 p.m., 8 of 10 quarterly fire drills which were conducted, occurred near the end of the month, around the 30th day of the month. These conditions do not allow fire drills to be conducted at on unexpected and unpredictable days. This finding was acknowledged by the Maintenance Technician at the time of discovery and again at the exit conference with the Maintenance Technician and Care Services Administrator present. 3.1-19(b)		occur: Director of Facilities or designee will audit fire drills monthly to ensure compliance. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place The Director of Facilities or designee will bring the results of the audits to the monthly QAPI Committee for review and recommendation. Any recommendation made by the committee will be followed up by the Director of Facilities or designee and the results will be brought to the next scheduled QAPI committee meeting. This practice will continue for a minimum of 3 months or longer if a pattern of non-compliance is shown.	
K 0781 SS=E Bldg. 02	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and			

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	employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation and interview, the facility failure to ensure 1 of 1 portable space heaters were not used in the facility. This deficient practice could affect up to 5 residents, staff and visitors in the vicinity of the Activities Area. Findings include: Based on observation and interview during a facility tour with the Maintenance Technician and Care Services Administrator on 04/04/23 between 12:15 p.m. and 2:30 p.m., a portable space heater was in use in the Activities Area. Based on interview at the time of the observations, the Care Services Administrator agreed a space heater was being used in the area and stated that such appliances were not allowed in the facility, and removed the space heater. This finding was acknowledged by the Maintenance Technician at the time of discovery and again at the exit conference with the Maintenance Technician and Care Services Administrator present. 3.1-19(b)	K 0781	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The nursing team will be educated regarding prohibited space heaters in the community. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. No further concerns were noted. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: The management staff, and cares services team will continually monitor rooms, and correct any deficiencies immediately. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place All noted deficiencies will be documented and brought to the monthly QAPI Committee for review and recommendation. Any recommendation made by the committee will be followed up by	06/02/2023

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			the Administrator. Results will be brought to the next scheduled QAPI committee meeting. This practice will continue for a minimum of 3 months or longer if a pattern of non-compliance is shown.	
K 0918 SS=F Bldg. 02	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 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,			

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	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) 1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 10 of the last 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. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. 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 occupants. Findings include: Based on records review and interview with the Maintenance Technician and Care Services Administrator on 04/04/23 between 9:45 a.m. and 12:15 p.m., prior 03/22 no documentation was available for review to show the diesel generator set in service was exercised at least once monthly, for a minimum of 30 minutes. The only monthly load test documentation provided reflected tests for March and April of 2023. The Maintenance Technician stated the monthly generator tests prior to 3/23 were conducted by the prior Maintenance Supervisor and did not know where the documentation was located.	K 0918	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Generator will have annual fuel quality test will be conducted. Generator will have monthly 30 minute load test completed. Generator will have three-year 4 hour test completed. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. No further concerns noted. Facilities team will be educated on generator testing requirements. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: Director of Facilities will adhere to the NFPA 110 requirements regarding testing of generators. Weekly, Monthly, and annual inspections will be documented. Any issues identified will require a work order placed for repair. How the corrective actions will be	06/02/2023

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	This finding was acknowledged by the Maintenance Technician at the time of discovery and again at the exit conference with the Maintenance Technician and Care Services Administrator present. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 facility's diesel-powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on records review and interview with the Maintenance Technician and Care Services Administrator on 04/04/23 between 9:45 a.m. and 12:15 p.m., no documentation of an annual fuel quality test for the diesel generator was available for review. The facility has 1 diesel fired generator. Based on interview at the time of records review, the fuel quality testing for the diesel fired generator could not be located. This finding was acknowledged by the Maintenance Technician at the time of discovery and again at the exit conference with the Maintenance Technician and Care Services		monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place The Director of Facilities or designee will bring audits to monthly QAPI Committee for review and recommendation until 100% compliance is met. Any recommendation made by the committee will be followed up by the Director of Facilities or designee.	

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	Administrator present. 3. Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: Based on records review and interview with the Maintenance Technician and Care Services Administrator on 04/04/23 between 9:45 a.m. and 12:15 p.m., the facility provided documentation for testing of the emergency generator, however, could not provide documentation of a three-year 4-hour test. This finding was acknowledged by the Maintenance Technician at the time of discovery and again at the exit conference with the Maintenance Technician and Care Services Administrator present. 3.1-19(b)			
K 0927 SS=E Bldg. 02	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders			

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	Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on records review and interview, the facility failed to ensure staff was properly trained on trans-filling procedures in 1 of 1 oxygen storage room where oxygen transferring takes place. NFPA 99 2012 edition, 11.5.2.3.1 (4) the individual trans-filling the container(s) has been properly trained in the trans-filling procedures. This deficient practice could affect up to 10 residents in one smoke compartment. Findings include: Based on records review and interview with the Maintenance Technician and Care Services Administrator on 04/04/23 between 9:45 a.m. and 12:15 p.m., no documentation was available for review to indicate staff that trans-fill liquid oxygen were properly trained. Based on interview at the time of observation, the Care Services Administrator stated staff are trained during orientation but was unable to provide the training paperwork. This finding was acknowledged by the Maintenance Technician at the time of discovery and again at the exit conference with the Maintenance Technician and Care Services	K 0927	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Nursing staff will be educated on trans-fill of liquid oxygen. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. No further concerns noted. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: Don or designee will audit new employee onboarding monthly to ensure that initial training and yearly education has been conducted. How the corrective actions will be monitored to ensure the deficient	06/02/2023

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	Administrator present. 3.1-19(b)		practice will not recur, I,e., what quality assurance program will be put into place The Director of Nursing or designee will bring audits to monthly QAPI Committee for review and recommendation until 100% compliance is met. Any recommendation made by the committee will be followed up by the Director of Facilities or designee.	