STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155733	A. BUILDING -- B. WING	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COLONIAL NURSING HOME	119 N INDIANA AVE CROWN POINT, IN 46307

(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: 09/18/2024 Facility Number: 000360 Provider Number: 155733 AIM Number: 100290370 At this Emergency Preparedness survey, Colonial Nursing Home was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 55 certified beds. At the time of the survey, the census was 33. Quality Review completed on 09/23/24	E 0000	sup="">th, 2024, to the annual licensure survey completed September 18th, 2024. The facility also requests that our plan of correction be considered for paper review compliance. The facility will submit any evidence as requested to validate compliance.	
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 requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator and Maintenance Director on 09/18/24 between 09:23 a.m. and 12:15 p.m., the generator lacked monthly load and weekly visual testing required	E 0041	/p> *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* ·All residents could potentially be harmed by the alleged deficient practice but none were identified. A generator testing occurred on 09/24/2024 *How other resident having the potential to be affected by the*	10/15/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Short	Administrator	10/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	by LSC and NFPA 110. Based on interview at the time of record review, the Maintenance Director acknowledged that documentation was missing for the generator. The findings was reviewed with the Administrator and Maintenance Director at the exit conference.		*same deficient practice will be identified and what corrective action(s) will be taken;* ·All residents residing in the facility could potentially be affected by the alleged deficient practice. An audit of the generator testing was conducted on 09/27/2024 for the monthly load testing and as well as the visual weekly check ·Additional education was provided to the Maintenance Director to ensure testing is being completed *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* ·The IDT reviewed policy and procedure on Generator Testing protocol ·A performance improvement tool has been developed to monitor monthly load testing and weekly visual checks *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly audits. This Quality Assurance Audit Tool will be completed by the Maintenance Director/Designee Weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue	

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			will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made:* *10/15/2024*	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey were conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/18/2024 Facility Number: 000360 Provider Number: 155733 AIM Number: 100290370 At this Life Safety Code survey, Colonial Nursing Home 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. Colonial Nursing Home is a two-story building with a basement of Type V (000) construction that was built at three different times. The original building was constructed in 1906 with additions constructed in 1986 and 1994. The building is fully sprinklered and there is supervised smoke detection located in the corridors, spaces open to	K 0000	sup="">th, 2024, to the annual licensure survey completed September 18th, 2024. The facility also requests that our plan of correction be considered for paper review compliance. The facility will submit any evidence as requested to validate compliance.	

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	the corridors and in resident rooms. The facility has 55 certified beds. All 55 beds are dually certified for Medicare and Medicaid. At the time of the survey, the census was 33. All areas where the residents have customary access and areas providing facility services were sprinklered. Quality Review completed on 09/23/24			
K 0161 SS=F Bldg. 01	NFPA 101 Building Construction Type and Height Based on observation and interview, the facility was not an acceptable type of construction as required by NFPA 101 - 2012 edition, Sections 19.1.6.1, 4.5.8 and NFPA 220 - 2012 edition, Section 4.1, 4.1.1 and Table 4.1.1. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation with the Maintenance Director and Administrator on 09/18/2024 during a tour of the facility from 12:26 p.m. to 1:26 p.m., observation of the unprotected wood structure revealed that the type of construction of the building was Type V (000) and the building was two stories. Type V (000) is not an acceptable type of construction for a two-story existing healthcare building. Based on interview at the time of observation, the Administrator acknowledged the unprotected construction. The finding was discussed with the Maintenance Director and Administrator at exit conference.	K 0161	/bk161> /b> An independent company, RTM, completed an FSES review in 2021 and determined all the Interstitial spaces of the basement levels and 2nd floor will require the installation of smoke and heat detectors. The new smoke detection system was installed in 2023 by Safecare. A new FSES score was completed on May 14, 2024 showing the new system that is currently in place giving the zones a passing FSES score. *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* ·All residents residing in the facility could potentially be affected by the alleged deficient practice but none were identified	10/15/2024

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	3.1-19(b)		·Administration will review FSES documentation annually and as needed. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* ·The IDT reviewed CMS guidelines on Use of fire safety evaluation system (FSES) ·A performance improvement tool has been developed to monitor that FSES and its accuracy *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly audits. This Quality Assurance Audit Tool will be completed by the Maintenance Director/Designee Weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made: 10/15/2024*	

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K 0225 SS=E Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Based on observation and interview, the facility failed to provide and maintain exit stairs and exit stair enclosures in accordance with NFPA 101 - 2012 edition, Sections 19.2, 19.2.1, 19.2.2.3, 7.1.3.2, 7.1.3.2.1, 7.1.3.2.3, 7.1.10, 7.1.10.1, 7.2.2, 7.2.2.1, 7.2.2.1.1, 7.2.2.3.3, 7.2.2.3.3.1, 7.2.2.3.3.4, 7.2.2.2, 7.2.2.2.1, 7.2.2.2.1.1, 7.2.2.5.3, 7.2.2.5.3.1, 7.2.2.5.3.2, 7.7.3, 7.7.3.4, 7.2.2.3.6, 7.2.2.3.6.1, 7.2.2.3.6.2, 8.2 and Table 7.2.2.2.1.1 (b). This deficient practice could affect approximately 12 residents and staff. Findings Include: Based on observations with the Administrator and Maintenance Director on 09/18/2024 during a tour of the facility from 12:26 p.m. to 1:26 p.m., the following was discovered: a) the exit stair by room 201 was not enclosed in fire rated construction. The door to the stair did not have fire resistance rating. b) the stair by room 201 consisted of metal open grate walking surfaces. The landing and all of the stair treads were metal open grate where there was 1/4 inch piece of metal and a 1 inch gap between the 1/4 inch metal pieces. This building is a healthcare occupancy. c) the stair by room 201 continued down from the upper landing 24 risers to the bottom of the stair without an intermittent landing. The approximately 15 foot distance exceeded the allowable maximum 12 foot distance between landing. d) the stair by room 201 only had a 30 inch clear width and not the required minimum 36 inch clear width. These findings were discussed with the Maintenance Director and Administrator at exit	K 0225	**K225 Stairways and Smokeproof Enclosures** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* Requesting compliance with alleged deficiency through the Life Safety Equivalency granted through the FSES was completed and a passing score was achieved. These stairs would only be used in an emergency situation, i.e. fire evacuation and do reach the sidewalk downstairs for egress to outside the building. Installation occurred from an independent contractor, Life Safety of all additional work needed to be upgrade the smoke detection system. Total coverage smoke detection included the installation of automatic smoke detection in all rooms, halls, storage areas, basements, attic, lofts, space above suspended ceilings, and other subdivisions and accessible spaces as well as the inside of all closets, elevators, shafts, ,enclosed stairways, dumb waiter shafts, and chutes. The facility has an updated FSES as of May 14, 2024 that reflects the updated system. *How other resident having the potential to be affected by the same deficient practice will be*	10/15/2024

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	conference. 3.1-19(b)		*identified and what corrective action(s) will be taken;* ·All residents residing in the facility could potentially be affected by the alleged deficient practice. Administration will review FSES documentation annually and as needed. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* ·The IDT reviewed CMS guidelines on Use of fire safety evaluation system (FSES) ·A performance improvement tool has been developed to monitor that FSES and its accuracy *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly audits. This Quality Assurance Audit Tool will be completed by the Maintenance Director/Designee Weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic*	

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K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure 1 of 2 sprinkler heads in the acitivities closet and 1 of 1 in basement resident bathroom were free of paint accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect approximately 16 residents and staff. Findings include: Based on observation with the Maintenance Director and Administrator on 09/18/24 between 12:26 p.m. and 1:26 p.m., one sprinkler head in a closet in the activities/resource office in the basement was observed to have foreign material/paint on the deflector that was not from the manufacturer. Furthermore, the resident bathroom in the basement, next to the conference room, had white foreign material on the sprinkler head. The material looked like overspray from paint as the escutcheon plate had been painted. Based on interview at the time of observation, the Maintenance Director acknowledged the materials on the two sprinkler heads. He agreed that the sprinkler heads should not have any foreign material on them.	K 0353	*changes will be made: 10/15/2024* K353 (F) Sprinkler System-Maintenance and Testing *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* ·All residents could potentially be harmed by the alleged deficient practice. The facility checked the pipe sprinkler system's gauges and has safecare checking all valves on 10/09/2024 as well as having the two valves replaced that were identified *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* ·All residents residing in the facility could potentially be affected by the alleged deficient practice. ·The facility checked the pipe sprinkler system's gauges and has safecare checking all valves on 10/09/2024 as well as having the two valves replaced that were identified ·1:1 education was provided to the Maintenance Director to ensure the pipe sprinkler system's gauges and valves are checked	10/15/2024

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	This finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		*What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* ·The IDT reviewed the policy on sprinkler system checks ·A performance improvement tool has been developed to monitor pipe sprinkler system's gauges and valves are being checked *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly audits. This Quality Assurance Audit Tool will be completed by the Maintenance Director/Designee Weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made: 10/15/2024*	
K 0531 SS=E Bldg. 01	NFPA 101 Elevators			

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	Based on record review and interview, the facility failed to maintain testing of 1 of 1 elevator firefighter recall in accordance with 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with fire fighters' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice would affect all occupants. Findings include: Based on record review with the Maintenance Director and Administrator on 09/18/24 between 09:23 a.m. and 12:15 p.m., the monthly testing for the elevator firefighter recall was missing testing for 8 of 12 months. The months of September & December of 2023 along with March through August 2024 were not documented. Based on interview at the time of record review, the Maintenance Director acknowledged the lack of documentation. He stated that the firefighter recall testing for the elevator was tested on a monthly basis, however he did not document it on the testing log in the life safety book. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0531	**K531 [E] Elevators** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* All residents could potentially be harmed by the alleged deficient practice but none were identified. A monthly test for firefighter recall was conducted on September 5th, 2024 ***How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:*** Potentially all residents could be affected but none were identified. A monthly test for firefighter recall was conducted on September 5th, 2024 ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:*** Monthly firefighters recall test was conducted IDT reviewed procedure for monthly recall testing for elevators ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur,***	10/15/2024

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			i.e., what quality assurance program will be put into place: An audit will be completed by maintenance or designee on elevator firefighters for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. ***The date the systemic changes will be completed:*** 10/15/2024	
K 0761 SS=F Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 7 of 7 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies.	K 0761	**K761 (F) Maintenance, Inspection, and Testing- Doors** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* ·All residents could potentially be harmed by the alleged deficient	10/15/2024

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	(See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states 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. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.		practice. A inspection of the 7 fire doors was conducted on 09/23/2024 *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* ·All residents residing in the facility could potentially be affected by the alleged deficient practice. An audit of the 7 fire doors was conducted on 09/23/2024. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* ·The IDT reviewed the fire door policy ·A performance improvement tool has been developed to monitor the fire watch policy is in place *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly audits. This Quality Assurance Audit Tool will be completed by the Maintenance Director/Designee Weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue	

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	(10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include: Based on record review with the Administrator and Maintenance Director on 09/18/24 between 09:23 a.m. and 12:15 p.m., no documentation of an annual inspection for the (7) fire door assemblies from the past 12 months were available for review. The last documented fire door assembly inspection was dated 08/01/23-08/03/23. a corridor checklist dated October and November 2023 did list stairway assembly doors being checked to make sure there were no gaps, latched and closer worked properly. However, the documentation did not list the other necessary requirements to be inspected on the sheet. Based on observation during the tour between 12:26 p.m. and 1:16 p.m., there are (6) one-hour fire door assemblies in the two stair wells. The facility also contains a 1-hour fire door assembly for the oxygen storage/transfilling room. Based on interview at the time of record review, the Maintneance Director stated that the fire marshals office was in the facility earlier in the year and checked certain fire door assemblies, however none of it was documented. He further stated that he has not done an inspection himself. The finding was discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made: 10/15/2024*	
K 0914 SS=F	NFPA 101 Electrical Systems - Maintenance and			

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	155733	A. BUILDING 01 B. WING	09/18/2024

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Bldg. 01	Testing Based on observation, record review and interview, the facility failed to ensure non-hospital grade electrical receptacles at 29 of 29 resident sleeping rooms were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Administrator on 09/18/24 between 12:26 a.m. and 1:26 p.m., the facility's 29 resident sleeping rooms contained approximately four non-hospital-grade electrical receptacles. Based on record review between 09:23 a.m. and 12:15 p.m., receptacle testing documentation was provided, however it was dated August of 2023. No other documentation could be provided to indicate that the testing had been completed within the past 12 months. Based on interview at the time of observation, the Maintenance Director acknowledged the lack of documentation. He further clarified that he was	K 0914	**K914 (F) Electrical Systems-Maintenance and Testing** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* ·All residents could potentially be harmed by the alleged deficient practice. A inspection of electrical receptacles conducted on 09/24/2024 *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* ·All residents residing in the facility could potentially be affected by the alleged deficient practice. An audit of the electrical receptacles conducted on 09/24/24 and 09/27/2024. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* ·The IDT reviewed the electrical receptacles. ·A performance improvement tool has been developed to monitor the fire watch policy is in place. *How the corrective actions will be monitored to ensure the deficient practice does not recur;*	10/15/2024

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	unaware the testing needed to be completed. Furthermore, the Administrator stated that the resting might have been completed this year by other personnel, but she was unsure where the documentation could be. The finding was reviewed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		A performance improvement tool has been initiated that randomly audits. This Quality Assurance Audit Tool will be completed by the Maintenance Director/Designee Weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made: 10/15/2024*	
K 0918 SS=F 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 7 of 12 months and weekly inspection for 4 of 52 weeks. 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. Section 8.4.1 requires an Emergency Power Supply System (EPSS) including all	K 0918	K918 (F) Electrical Systems-Essential Electric Systems *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* ·All residents could potentially be harmed by the alleged deficient practice but none were identified. A generator testing occurred on 09/24/2024 *How other resident having the*	10/15/2024

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	appurtenant components, shall be inspected weekly and exercised monthly. 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 record review with the Administrator and Maintenance Director on 09/18/24 between 09:23 a.m. and 12:15 p.m., no documentation was available for the months between January 2024 and August 2024 to show the generator set in service was exercised at least once monthly, for a minimum of 30 minutes. Also, the generator weekly inspection log showed that documentation for the following weeks were missing a) September 24-September 30 of 2023 b) October 22-October 28 of 2023 c) November 26-December 2 of 2023 d) December 24-December 30 of 2023 Based on interview at the time of record review, the Maintenance Director acknowledged that there were weekly inspections missing and further stated that he was not at the facility during that time and was unsure if the inspections had been completed. He further clarified that he was unaware that the generator needed to be exercised under load each month. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		*potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* ·All residents residing in the facility could potentially be affected by the alleged deficient practice. An audit of the generator testing was conducted on 09/27/2024 for the monthly load testing and as well as the visual weekly check ·Additional education was provided to the Maintenance Director to ensure testing is being completed *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* ·The IDT reviewed policy and procedure on Generator Testing protocol ·A performance improvement tool has been developed to monitor monthly load testing and weekly visual checks *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly audits. This Quality Assurance Audit Tool will be completed by the Maintenance Director/Designee Weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further	

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			concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made: 10/15/2024*	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 2 of 2 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 15 residents and staff. Findings include: Based on observation during a tour of the facility with the Maintenance Director and Administrator on 09/18/24 between 12:26 p.m. and 1:26 p.m., two refrigerators (high power draw equipment) were plugged into and supplied power by a power strip near the first floor nurses station. Furthermore, a minifridge (high power draw equipment) was plugged into and powered by a power strip in the activities/resource office in the basement. Based on interview at the time of observation, the Administrator acknowledged the items were plugged into the fridges. She further stated that they are working to remove all power strips in the facility.	K 0920	**K920 (E) Electrical Systems-Power Cords and Extensions** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* ·Extension cords and power strips were removed from all rooms in the facility ·Electrician will be coming out on 10/4/2024 to add in outlets for two locations identified so no extension cords would be needed in that area *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* ·All residents residing in the facility could potentially be affected by the alleged deficient practice. An audit of the power strips and extension cords was conducted on 9/20/2024. · 1:1 education was provided to	10/15/2024

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	This finding was reviewed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		the Maintenance Director to ensure facility is free from extension cords and power strips *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* ·The IDT reviewed the power strip and extension cord policy ·A performance improvement tool has been developed to monitor the fire watch policy is in place. *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly audits. This Quality Assurance Audit Tool will be completed by the Maintenance Director/Designee Weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made: 10/15/2024*	