STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155770	A. BUILDING -- B. WING	05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VILLAS OF GUERIN WOODS	1002 SISTER BARBARA WAY GEORGETOWN, IN 47122

(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 Dates: 05/10/23 and 05/11/2023 Facility Number: 011509 Provider Number: 155770 AIM Number: 200909280 At this Emergency Preparedness survey, Villas of Guerin Woods was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 68 certified beds, with a current census of 66. Quality Review completed on 05/17/23 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	**Plan of Correction for the Villas of Guerin Woods 2023 Life Safety Code with Emergency Preparedness Survey.** **The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation**. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of the Post Survey Revisit.	
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Eric Will	Administrator	06/01/2023

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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	155770	A. BUILDING -- B. WING	05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VILLAS OF GUERIN WOODS	1002 SISTER BARBARA WAY GEORGETOWN, IN 47122

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	The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			

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	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all residents in the facility. Findings include: Based on review of the Emergency Preparedness plan on 05/11/23 between 9:30 a.m. and 10:00 a.m. with the Maintenance Director present, the facility did provide an emergency preparedness manual, however, it has not been reviewed and updated during the past twelve months. The most recent date of review provided was 09/04/19. Based on interview at the time of review, the Maintenance Director said he has only been working at the facility for the past four months and has not seen evidence that the Emergency Preparedness plan has been reviewed and updated within the past twelve months. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23.	E 0004	**E 004** **What corrective action was taken for residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. The Emergency Preparedness Plan has been reviewed and updated for 2023. **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. The facilities Emergency Preparedness plan has been reviewed and updated for 2023. **What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the requirements for reviewing and updating the Emergency Preparedness Plan annually or as needed. The Emergency Preparedness Plan will be reviewed and updated in the December QA meeting for the upcoming year. This practice will be ongoing every December. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e. what quality**	06/19/2023

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			assurance program will be put into place? The Quality Assurance Committee will review the Emergency Preparedness plan monthly to ensure the plan has been reviewed and updated as needed and or annually. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency			

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	preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are			

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	not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: Based on review of the Emergency Preparedness plan on 05/11/23 between 9:30 a.m. and 10:00 a.m. with the Maintenance Director present, there was documentation in the plan for facility policies and procedures, however the policies and procedures have not been reviewed by the facility within the most recent twelve month period. The most recent date of review provided was 09/04/19. Based on interview at the time of review, the Maintenance Director said he has only been working at the facility for the past four months and has not seen evidence that the Emergency Preparedness plan has been reviewed and updated within the past twelve months. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23.	E 0013	**E 113** **What corrective action was taken for residents found to have been affected by the deficient practice?** The Emergency Preparedness Plan's policies and procedures have been reviewed and updated for 2023. **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. The Emergency Preparedness Plan's policies and procedures have been reviewed and updated for 2023. **What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the requirements for reviewing and updating the Emergency Preparedness policies and procedures annually and as needed. The policies and procedures will be reviewed and updated in the December Quality Assurance meeting for the	06/19/2023

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			upcoming year. This practice will be ongoing every December. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review and update the Emergency Preparedness Plan's policies during the monthly QA meeting to ensure the plan has been reviewed and updated as needed and or least annually. By what date will the systemic changes for each deficiency be completed? 6/19/2023	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility	E 0029	**E 029**	06/19/2023

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	failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness plan on 05/11/23 between 9:30 a.m. and 10:00 a.m. with the Maintenance Director present, the facility's emergency preparedness plan provided did include a plan to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws, however the communication plan has not been reviewed by the facility within the most recent twelve month period. The most recent date of review provided was 09/04/19. Based on interview at the time of review, the Maintenance Director said he has only been working at the facility for the past four months and has not seen evidence that the Emergency Preparedness plan has been reviewed and updated within the past twelve months. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23.		**What corrective action was taken for residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. The Emergency Preparedness Communication Plan has been reviewed and updated. The plan complies with Federal, State, and Local laws and it will be reviewed and updated at least every 2 years. **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. The Emergency Preparedness Communication Plan has been reviewed and updated. The plan complies with Federal, State, and Local laws and it will be reviewed and updated at least every 2 years. **What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the requirements for reviewing a/nd updating the Emergency Preparedness Communication Plan. The Emergency Preparedness Communication Plan will be reviewed and updated	

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			in the December Quality Assurance meeting for the upcoming year. This practice will be ongoing every December. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Emergency Preparedness Communication Plan monthly to ensure the plan has been reviewed and updated as needed and or at least annually. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under			

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	485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training			

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	at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness plan on 05/11/23 between 9:30 a.m. and 10:00 a.m. with the Maintenance Director present, there was documentation available to show the facility had an emergency preparedness training and testing program, however the training and testing program has not been reviewed by the facility within the most recent twelve month period. The most recent date of review provided was 09/04/19. Based on interview at the time of review, the Maintenance Director said he has only been working at the facility for the past four months and has not seen evidence that the Emergency Preparedness plan has been reviewed and updated within the past twelve months.	E 0036	**E 036** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. The facility's Emergency Preparedness training and testing program was reviewed and updated. **How will you 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 alleged deficient practice. The facility's Emergency Preparedness training and testing program was reviewed and updated.	06/19/2023

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	This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23.		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the requirements of the Emergency Preparedness testing and training program. The Emergency Preparedness training and testing program Plan will be reviewed and updated in the December Quality Assurance meeting for the upcoming year. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Emergency Preparedness training and testing program plan to ensure it has been reviewed and updated as needed and or at least annually during the December monthly QA meeting. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2)			

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	EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group			

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	discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated,			

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	clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.			

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	*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):]			

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	(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per			

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	year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:			

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	(i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual			

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	individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or			

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	prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural	E 0039	**E 039** **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. The facility conducted an exercise that was community-based to test the emergency plan and supporting documentation is readily available.	06/19/2023

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	or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants in the facility. Findings include: Based on review of the Emergency Preparedness plan on 05/11/23 between 9:30 a.m. and 10:00 a.m. with the Maintenance Director present, the facility was unable to provide documentation of a community based exercise during the past 12 months, and was further unable to provide documentation of a second exercise conducted during the past twelve months. The Maintenance Director said he has only been working at the facility for the past four months and has not seen evidence that two exercises have been performed in relation to the Emergency Preparedness plan		The second exercise has been scheduled. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff, and families had the potential to be affected by this alleged deficient practice. The facility conducted an exercise that was community-based to test the emergency plan and supporting documentation is readily available. The second exercise has been scheduled. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** The maintenance director has been educated on the requirements of the Emergency Preparedness testing as related to an annual community-based exercise and the requirements for the second exercise. The administrator and maintenance director will schedule and plan each exercise to ensure the requirements are met. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put**	

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	within the past twelve months. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23.		**into place?** The Quality Assurance Committee will review the Emergency Preparedness planned exercises and completed exercises at the monthly meeting to ensure compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
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. 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,			

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	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 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			

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	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. (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 applies to all Villas except Villa 1 which is an	E 0041	**E 041** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have been affected by this alleged deficient practice. The facilities five	06/19/2023

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VILLAS OF GUERIN WOODS	1002 SISTER BARBARA WAY GEORGETOWN, IN 47122

(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
	Assisted Living Villa, and Villa 4 which does not have an emergency generator, furthermore, Villas 7 and 8 share an emergency generator. This includes five emergency generators. 1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 5 of 5 generators was maintained for 31 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors in each Villa. Findings include: Based on review of the generator inspection reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available to show the emergency generator was inspected/tested weekly during 31 of the most recent 52 week period (nothing since 10/03/22). Based on interview at the time of record review, the Maintenance Director said he does test/inspect each of the five emergency generators weekly but does not always document the test/inspection results.		generators have the require weekly inspections, monthly load toad test, annual maintenance, and 4-hour load test completed and documented according to the NFPA emergency power and standby system requirements. **How will you 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 alleged deficient practice. The facilities five generators have the require weekly inspections, monthly load toad test, annual maintenance, and 4-hour load test completed and documented according to the NFPA emergency power and standby system requirements. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the NFPA's TLC emergency and standby power system requirements. The administrator/designee will complete the Performance Improvement Tool after reviewing the weekly inspections/testing documentation weekly, the monthly load toad test documentation during the	

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	This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 5 of 5 generators during 6 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors in each Villa. Findings include: Based on record review on 05/10/23 between 9:30		scheduled monthly Quality Assurance meeting and the annual maintenance and 4-hour load test documentation during each Decembers scheduled QA meeting to ensure the requirements are met. This practice will be ongoing. Non-compliance of weekly inspections/testing documentation weekly, the monthly load toad test documentation will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool at the scheduled monthly QA meeting to ensure the NFPA's TLC emergency and standby power system requirements are being met. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	

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	a.m. and 3:30 p.m. with the Maintenance Director present, there was no monthly generator load test documentation available for 6 of the past 12 months (nothing since 09/26/22) for the five emergency generators. Based on interview at the time of record review, the Maintenance Director confirmed there was no emergency generator load test documentation for 6 of the past 12 months for the five emergency generators. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3. Based on record review and interview, the facility failed to ensure a written record of routine maintenance and testing for 5 of 5 emergency generators was maintained and available. NFPA 110, the Standard for Emergency and Standby Powers Systems, at 8.3.3 requires a written schedule for routine maintenance and operational testing of the EPSS shall be established. 8.3.4 requires a permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. 8.3.4.1 requires the permanent record shall include the following: (1) The date of the maintenance report (2) Identification of the servicing personnel (3) Notification of any unsatisfactory condition and the corrective action taken, including parts replaced (4) Testing of any repair for the time as recommended by the manufacturer. This deficient practice could affect all residents, staff and visitors in each Villa. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available to			

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	show that the five emergency generators have had routine maintenance during the past 12 months. Based on interview at the time of record review, the Maintenance Director said he has been the Maintenance Director at the facility for only four months and has not seen evidence/documentation that routine maintenance has been performed on the five generators either in house or from an outside vendor. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 4. Based on record review and interview, the facility failed to provide complete documentation for the testing of 5 of 5 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. NFPA 110, Section 8.4.9.5.3 states for spark-ignited (LP or Natural Gas) EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility could not provide documentation of a four hour load test of the LP			

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	gas fueled emergency generator within the past 36 months for the five emergency generators. This was confirmed by the Maintenance Director at the time of record review. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23.			
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Dates: 05/10/23 and 05/11/23 Facility Number: 011509 Provider Number: 155770 AIM Number: 200909280 At this Life Safety Code survey, Villas of Guerin Woods, 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), and 410 IAC 16.2. Villa 1002 was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 10 and had a census of 10 at the time of this visit.	K 0000	**Plan of Correction for the Villas of Guerin Woods 2023 Life Safety Code with Emergency Preparedness Survey.** **The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation**. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of the Post Survey Revisit.	

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	All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 05/17/23			
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review, observation, and interview; the facility failed to ensure there was documentation for the testing of 5 of 5 battery backup lights that were tested monthly for 30 seconds during 6 of the past 12 months, and annually for 90 minutes during the past 12 months to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review on 05/10/23 between 9:30	K 0291	**K 291** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. All 5 of the facilities battery backup lights that were tested for 90 minutes and documented accordingly. **How will you 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 alleged deficient practice. All 5 of the facilities' battery backup lights were tested for 90 minutes and documented accordingly. **What measures will be put into**	06/19/2023

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	a.m. and 3:30 p.m. with the Maintenance Director present, the facility did have a preventative maintenance (PM) report that battery powered emergency lights were tested monthly, however, there was no 30 second monthly testing documentation since 09/26/22. Furthermore, there was no documentation available to show the five battery powered emergency lights were tested annually for 90 minutes. Based on an interview at the time of record review, the Maintenance Director agreed the PM form for the battery powered emergency lights did not include 30 second monthly testing for each battery powered light since 09/26/22. Furthermore, he said there was no documentation available for an annual 90 minute test during the past 12 month period. During a tour of the facility with the Maintenance Director on 05/11/23 between 10:00 a.m. and 12:00 p.m., the facility was equipped with five emergency battery powered lights. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		**place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the NFPA's emergency battery backup lighting's testing requirements. The 5 battery backup lights will be tested monthly by the maintenance director/designee for 30 seconds and 90 minutes annually with completed documentation. The administrator/designee will complete a Performance Improvement Tool monthly for 6 months after reviewing the monthly testing report to ensure the light will provide lighting during a power outage. Non-compliance with emergency battery backup lighting testing will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review Performance Improvement Tool related to emergency battery backup lighting's monthly testing for compliance and further recommendations during the scheduled monthly meeting.	

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			. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0324 SS=C Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction	K 0324	**E 324** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. The kitchen	06/19/2023

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	and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the only inspection documentation available during the past twelve months for the range hood exhaust system was dated 04/20/23. There was no range hood exhaust system inspection report available within six months prior to the 04/20/23 date. Based on interview at the time of record review, the Maintenance Director said he could not find a range hood exhaust system inspection within six months prior to the 04/20/23 date.		exhaust system in the identified Villa has been inspected and cleaned. **How will you 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 alleged deficient practice. The kitchen exhaust systems in the other 7 villas have been inspected and cleaned if indicated by the inspection. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations requirements as related to required inspections and cleaning of the ventilation system. The inspection will be scheduled by the maintenance director/designee for monthly and annual inspections/cleaning. The administrator/designee will complete a Performance Improvement Tool monthly to ensure the inspections were completed and the findings were addressed as needed. Non-compliance with required testing inspections and cleanings	

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	This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to kitchen ventilation inspections for compliance and to make further recommendations as needed. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. Based on record review and interview, the facility failed to ensure the annual testing of all devices connected to 1 of 1 fire alarm system was performed. NFPA 72, National Fire Alarm Code, the 2010 Edition, at 14.6.2.4 requires a record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information	K 0345	**K 345** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged	06/19/2023

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	requested in Figure 14.6.2.4: (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency (ies) (7) Designation of the detector(s) tested (8) Functional test of detectors (9)*Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Functional test of mass notification system control units (13) Functional test of signal transmission to mass notification systems (14) Functional test of ability of mass notification system to silence fire alarm notification appliances (15) Tests of intelligibility of mass notification system speakers (16) Other tests as required by the equipment manufacturer's published instructions (17) Other tests as required by the authority having jurisdiction (18) Signatures of tester and approved authority representative (19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place) This deficient practice could affect all occupants in the facility. Findings include:		deficient practice. The components of the identified Fire Alarm System have been tested, calibrated as needed, and inspected per the NFPA 70, National, Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff, and visitors have the potential to be affected by the alleged deficient practice. The facilities other Fire Alarm Systems have been tested, calibrated as needed, and inspected per the NFPA 70, National, Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on testing and maintenance of a fire alarm system accordance with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code and that documentation is readily available for review. The	

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	Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility was able to provide a semi-annual visual fire alarm system inspection report dated 06/24/22 performed by the facility's maintenance staff, however, there was no documentation available for an annual visual inspection and functional test of all devices connected to the fire alarm system. Based on interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure documentation was available to show that all smoke detectors were sensitivity tested within the past 24 months or prior. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods:		administrator/designee will complete a Performance Improvement Tool monthly to ensure the testing, recalibration as needed, and inspections are completed per regulations. Non-compliance with required testing, calibration, and inspection will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to Fire Alarm Systems for compliance and for further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	

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	(1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility was unable to produce a smoke detector sensitivity report for all smoke detectors for the past 24 month period. Based on interview at the time of record review, the Maintenance Director confirmed there was no smoke detector sensitivity testing documentation available for the past 24 months. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)			
K 0353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing			

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Bldg. 01	Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 dry sprinkler system during 41 of the past 52 weeks. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff,	K 0353	**E 353** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The identified facility's dry sprinkler system gauges and control valve were inspected, and maintenance performed as indicated. The documentation is readily available. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff, and visitors have the potential to be affected by the alleged deficient practice.	06/19/2023

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	and visitors in the facility. Findings include: a. Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available to show the facility's dry sprinkler system gauges were inspected weekly during 41 of the past 52 week period. Based on interview at the time of record review, the Maintenance Director confirmed there was no documentation available to show that the facility's sprinkler gauges have been inspected at least weekly during 41 of the past 52 weeks. Based on observations with the Maintenance Director during a tour of the facility on 05/11/23 between 10:00 a.m. and 12:00 p.m. the facility had three pressure gauges at the sprinkler riser. b. Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no monthly sprinkler system control valves inspection documentation for 8 of the past 12 months. Based on interview at the time of record review, the Maintenance Director confirmed the lack of sprinkler system inspections on the control valves during the past 12 months. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		An audit was completed on the remainder Villas to identify sprinkler system gauges and control valve were not inspected and lacking maintenance as required. The identified areas were corrected. The documentation is readily available. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the facility's dry sprinkler system gauges, control valves, required inspections, and maintenance. The administrator/designee will complete a Performance Improvement Tool after reviewing the monthly documentation of the weekly and monthly inspections and maintenance that is performed as required. Non-compliance of the required weekly and monthly inspections and required maintenance will result in disciplinary action up to and including termination **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance	

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			Improvement Tool related to sprinkler system gauges and control valve inspections, and required maintenance for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected 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 provide quarterly fire drill documentation for 3 of 3 shifts during 2 of 4 quarters. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's fire drill reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility lacked fire drill documentation for the following shifts and quarters during the past 12 month	K 0712	**K 712** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. Fire drills have been conducted on both shifts (Days, Nights) in all 8 villas. Documentation is readily available. **How will you identify other**	06/19/2023

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	period: a. First shift (day) of the first quarter (January, February, and March) of 2023 b. Second shift (evening) of the second quarter (April, May, and June) of 2022 and so far in 2023 c. Third shift (night) of the first quarter (January, February, and March) of 2023 Based on interview at the time of record review, the Maintenance Director confirmed the lack of fire drill reports during the previously mentioned shifts and quarters. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to provide complete fire drill documentation for 1 of 9 fire drills performed during the past 12 month period. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the documented fire drill report performed on 03/28/23 (second shift of the first quarter) did not include the names and signatures of staff that participated in the fire drill. Based on interview at the time of record review, the Maintenance Director confirmed the lack of staff signatures on the fire drill report dated 03/28/23. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23.		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff and visitors have the potential to be affected by the alleged deficient practice. Fire drills have been conducted on both shifts (Days, Nights) at expected and unexpected times under various conditions in all 8 villas. Documentation includes employee signatures that participated in each drill and transmission of the alarm that was received by monitoring company. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the requirements of conducting monthly fire drills in all 8 Villas on both day shift and night shift at expected and unexpected times under various conditions and the required documentation of those that participated in the drills and transmission of the alarm that was received by the monitoring company. The administrator/designee will complete a Performance Improvement Tool to ensure the monthly fire drills were conducted at expected and unexpected times under various conditions monthly	

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	3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 3 of 9 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, fire drill reports dated 08/27/22, 10/27/22 and 03/28/23 were not provided with documentation for the transmission of the alarm to the monitoring company. Based on interview at the time of record review, the Maintenance Director acknowledged there was no information on the previously mentioned fire drill reports to verify that transmission of the alarm was received by the monitoring company. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3-1.19(b)		on both shifts and validate proper documentation is completed. Non-compliance with required fire drills and documentation will result in disciplinary action up to and including termination **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to the competition and proper documentation of the required fire drills for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed			

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	locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)			
	Based on observation, record review and interview; the facility failed to ensure complete documentation was available for all nonhospital-grade electrical receptacles in all resident room locations 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	K 0914	**K 914** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. Non-hospital grade receptacles in resident rooms have been tested for polarity, continuity of ground circuit, and retention force of grounding blade. Receptacles were replaced as indicated by the tests. **How will you identify other**	06/19/2023

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	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 record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available of an annual resident room receptacle test for non hospital-grade receptacles. Based on interview at the time of record review, the Maintenance Director said all of the electrical receptacles in resident rooms were not hospital-grade receptacles as far as he knew. He further said he has been the Maintenance Director at the facility for only four months and could not find documentation to show that annual testing per NFPA 99, Receptacle Testing requirements was met with all pertinent information within the past 12 month period or prior. Based on observations on 05/11/23 between 10:00 a.m. and 12:00 p.m. during a tour of the facility with the Maintenance Director, there were at least four electrical receptacles in each resident room. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff and visitors have the potential to be affected by the alleged deficient practice. Non-hospital grade receptacles in resident rooms have been tested for polarity, continuity of ground circuit, and retention force of grounding blade. Receptacles were replaced as indicated by the tests. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director was educated on documenting the annual testing of non-hospital grade receptacles in resident rooms, to include testing for polarity, continuity of ground circuit, and retention force of the grounding blade. Receptacles were replaced as indicated by the tests. The administrator/designee will complete a Performance Improvement Tool to ensure non-hospital grade receptacles are tested annually, replace when indicated by testing, and required documentation. Non-compliance with required annual test will result in disciplinary action up to and including termination	

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			How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Quality Assurance Committee will review the Performance Improvement Tool related to testing non-hospital grade receptacles annually for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES			

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	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, 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 ensure a written record of weekly inspections for 1 of 1 generator was maintained for 31 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include:	K 0918	**K 918** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. The facilities five generators have the require weekly inspections/tested, monthly load toad test, annual maintenance, and 4-hour load test completed and documented according to meet NFPA emergency power and standby system requirements. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff, and visitors	06/19/2023

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	Based on review of the generator inspection reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available to show the emergency generator was inspected/tested weekly during 31 of the most recent 52 week period (nothing since 10/03/22). Based on interview at the time of record review, the Maintenance Director said he does test/inspect of the emergency generator weekly but does not always document the test/inspection results. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 6 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full		have the potential to be affected by the alleged deficient practice. The facilities five generators have the require weekly inspections/tested, monthly load toad test, annual maintenance, and 4-hour load test completed and documented according to meet NFPA emergency power and standby system requirements. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the NFPA's LTC emergency and standby power system requirements. The administrator/designee will complete the Performance Improvement Tool for 6 months after reviewing the weekly inspections/testing documentation weekly, the monthly load toad test documentation during the scheduled monthly Quality Assurance meeting and the annual maintenance and 4-hour load test documentation during each Decembers scheduled QA meeting to ensure the requirements are met. This practice will be ongoing. Non-compliance of weekly inspections/testing documentation weekly, the monthly load toad test documentation will result in disciplinary action up to and	

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VILLAS OF GUERIN WOODS	1002 SISTER BARBARA WAY GEORGETOWN, IN 47122

(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
	compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no monthly generator load test documentation available for 6 of the past 12 months (nothing since 09/26/22) for the emergency generator. Based on interview at the time of record review, the Maintenance Director confirmed there was no emergency generator load test documentation for 6 of the past 12 months for the emergency generator. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 3. Based on record review and interview, the facility failed to ensure a written record of routine maintenance and testing for 1 of 1 emergency generator was maintained and available. NFPA 110, the Standard for Emergency and Standby Powers Systems, at 8.3.3 requires a written schedule for routine maintenance and operational testing of the EPSS shall be established. 8.3.4 requires a permanent record of the EPSS inspections, tests, exercising, operation, and		including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related emergency and standby power system requirements for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	

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	repairs shall be maintained and readily available. 8.3.4.1 requires the permanent record shall include the following: (1) The date of the maintenance report (2) Identification of the servicing personnel (3) Notification of any unsatisfactory condition and the corrective action taken, including parts replaced (4) Testing of any repair for the time as recommended by the manufacturer. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available to show that the emergency generator has had routine maintenance during the past 12 months. Based on interview at the time of record review, the Maintenance Director said he has been the Maintenance Director at the facility for only four months and has not seen evidence/documentation that routine maintenance has been performed on the generator either in house or from an outside vendor. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 4. Based on record review and interview, the facility failed to provide complete documentation for the testing of 5 of 5 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			

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	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. NFPA 110, Section 8.4.9.5.3 states for spark-ignited (LP or Natural Gas) EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility could not provide documentation of a four hour load test of the LP gas fueled emergency generator within the past 36 months for the five emergency generators. This was confirmed by the Maintenance Director at the time of record review. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)			
K 0000 Bldg. 03	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 Dates: 05/10/23 and 05/11/23 Facility Number: 011509	K 0000	**Plan of Correction for the Villas of Guerin Woods 2023 Life Safety Code with Emergency Preparedness Survey.** **The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set**	

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	Provider Number: 155770 AIM Number: 200909280 At this Life Safety Code survey, Villas of Guerin Woods, 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), and 410 IAC 16.2. Villa 1004 was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 10 and had a census of 10 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 05/17/23		**forth in the statement of deficiencies, or of any violation of regulation**. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of the Post Survey Revisit.	
K 0291 SS=F Bldg. 03	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review, observation, and interview; the facility failed to ensure there was documentation for the testing of 5 of 5 battery backup lights that were tested monthly for 30 seconds during 6 of the past 12 months, and annually for 90 minutes during the past 12 months	K 0291	**K 291** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	06/19/2023

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	to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility did have a preventative maintenance (PM) report that battery powered emergency lights were tested monthly, however, there was no 30 second monthly testing documentation since 09/26/22. Furthermore, there was no documentation available to show the five battery powered emergency lights were tested annually for 90 minutes. Based on an interview at the time of record review, the Maintenance Director agreed the PM form for the battery powered emergency lights did not include 30 second monthly testing for each battery powered light since 09/26/22. Furthermore, he said there was no documentation available for an annual 90 minute test during the past 12 month period. During a tour of the facility with the Maintenance Director on 05/11/23 between 10:00 a.m. and 12:00 p.m., the facility was equipped with five emergency battery powered lights.		No residents were found to have been affected by this alleged deficient practice. All 5 of the facilities battery backup lights that were tested for 90 minutes and documented accordingly. **How will you 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 alleged deficient practice. All 5 of the facilities' battery backup lights were tested for 90 minutes and documented accordingly. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the NFPA's emergency battery backup lighting's testing requirements. The 5 battery backup lights will be tested monthly by the maintenance director/designee for 30 seconds and 90 minutes annually with completed documentation. The administrator/designee will complete a Performance Improvement Tool monthly for 6 months after reviewing the monthly testing report to ensure the light will provide lighting during a power	

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	This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		outage. Non-compliance with emergency battery backup lighting testing will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review Performance Improvement Tool related to emergency battery backup lighting's monthly testing for compliance and further recommendations during the scheduled monthly meeting. . **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0321 SS=F Bldg. 03	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			

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	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) 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 1 egress corridor in 1 of 2 smoke compartments was not used to store combustible material. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations on 05/11/23 between 10:00 a.m. and 12:00 p.m. during a tour of the facility with the Maintenance Director, the Beauty Shop area of the back hall was being used to store several plastic drawer type totes full of items, cardboard boxes, old furniture, and mattresses, and a variety of other storage items. This area was open to the egress corridor. Based on interview at the time of observation, the Maintenance Director said this area has been this way ever since he's been at the facility.	K 0321	**K 321** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. The combustible materials that were in beauty shop were removed. **How will you 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 alleged deficient	06/19/2023

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	This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		practice. The facility conducted an audit to ensure combustible materials are not stored in egress corridors in smoke compartments. Identified items were removed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on proper storage of combustible materials and that combustible materials must be moved if they are identified as being stored appropriately. The maintenance director/designee will complete daily rounds to identify non-compliance with storing combustible materials and correct immediately. The administrator will complete a weekly Performance Improvement tool to identify continued non-compliance. Non-compliance with daily environmental rounds and combustible material storage will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool and make further recommendations or	

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			changes as needed during the scheduled monthly meeting. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0324 SS=C Bldg. 03	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s)	K 0324	**E 324** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged	06/19/2023

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	acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the only inspection documentation available during the past twelve months for the range hood exhaust system was dated 04/20/23. There was no range hood exhaust system inspection report available within six months prior to the 04/20/23 date. Based on interview at the time of record review, the Maintenance Director said he could not find a range hood exhaust system inspection within six months prior to the 04/20/23 date.		deficient practice. The kitchen exhaust system in the identified Villa has been inspected and cleaned. **How will you 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 alleged deficient practice. The kitchen exhaust systems in the other 7 villas have been inspected and cleaned if indicated by the inspection. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations requirements as related to required inspections and cleaning of the ventilation system. The inspection will be scheduled by the maintenance director/designee for monthly and annual inspections/cleaning. The administrator/designee will complete a Performance Improvement Tool monthly to ensure the inspections were completed and the findings were addressed as needed. Non-compliance with required	

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	This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		testing inspections and cleanings will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to kitchen ventilation inspections for compliance and to make further recommendations as needed. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0345 SS=F Bldg. 03	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. Based on record review and interview, the facility failed to ensure the annual testing of all devices connected to 1 of 1 fire alarm system was performed. NFPA 72, National Fire Alarm Code, the 2010 Edition, at 14.6.2.4 requires a record of all inspections, testing, and maintenance shall be provided that includes the following information	K 0345	K 345 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have been affected by this alleged	06/19/2023

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	regarding tests and all the applicable information requested in Figure 14.6.2.4: (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency (ies) (7) Designation of the detector(s) tested (8) Functional test of detectors (9)*Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Functional test of mass notification system control units (13) Functional test of signal transmission to mass notification systems (14) Functional test of ability of mass notification system to silence fire alarm notification appliances (15) Tests of intelligibility of mass notification system speakers (16) Other tests as required by the equipment manufacturer's published instructions (17) Other tests as required by the authority having jurisdiction (18) Signatures of tester and approved authority representative (19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place) This deficient practice could affect all occupants in the facility.		deficient practice. The components of the identified Fire Alarm System have been tested, calibrated as needed, and inspected per the NFPA 70, National, Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents, staff, and visitors have the potential to be affected by the alleged deficient practice. The facilities other Fire Alarm Systems have been tested, calibrated as needed, and inspected per the NFPA 70, National, Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The Maintenance Director has been educated on testing and maintenance of a fire alarm system accordance with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code and that documentation is readily available for review. The administrator/designee will	

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	Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility was able to provide a semi-annual visual fire alarm system inspection report dated 06/24/22 performed by the facility's maintenance staff, however, there was no documentation available for an annual visual inspection and functional test of all devices connected to the fire alarm system. Based on interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure documentation was available to show that all smoke detectors were sensitivity tested within the past 24 months or prior. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity		complete a Performance Improvement Tool monthly to ensure the testing, recalibration as needed, and inspections are completed per regulations. Non-compliance with required testing, calibration, and inspection will result in disciplinary action up to and including termination. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Quality Assurance Committee will review the Performance Improvement Tool related to Fire Alarm Systems for compliance and for further recommendations. By what date will the systemic changes for each deficiency be completed? 6/19/2023	

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	range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility was unable to produce a smoke detector sensitivity report for all smoke detectors for the past 24 month period. Based on interview at the time of record review, the Maintenance Director confirmed there was no smoke detector sensitivity testing documentation available for the past 24 months. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)			

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K 0353 SS=F Bldg. 03	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 dry sprinkler system during 41 of the past 52 weeks. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the	K 0353	**E 353** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The identified facility's dry sprinkler system gauges and control valve were inspected, and maintenance performed as indicated. The documentation is readily available. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff, and visitors	06/19/2023

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	authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: a. Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available to show the facility's dry sprinkler system gauges were inspected weekly during 41 of the past 52 week period. Based on interview at the time of record review, the Maintenance Director confirmed there was no documentation available to show that the facility's sprinkler gauges have been inspected at least weekly during 41 of the past 52 weeks. Based on observations with the Maintenance Director during a tour of the facility on 05/11/23 between 10:00 a.m. and 12:00 p.m. the facility had three pressure gauges at the sprinkler riser. b. Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no monthly sprinkler system control valves inspection documentation for 8 of the past 12 months. Based on interview at the time of record review, the Maintenance Director confirmed the lack of sprinkler system inspections on the control valves during the past 12 months. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		have the potential to be affected by the alleged deficient practice. An audit was completed on the remainder Villas to identify sprinkler system gauges and control valve were not inspected and lacking maintenance as required. The identified areas were corrected. The documentation is readily available. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the facility's dry sprinkler system gauges, control valves, required inspections, and maintenance. The administrator/designee will complete a Performance Improvement Tool after reviewing the monthly documentation of the weekly and monthly inspections and maintenance that is performed as required. Non-compliance of the required weekly and monthly inspections and required maintenance will result in disciplinary action up to and including termination **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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			The Quality Assurance Committee will review the Performance Improvement Tool related to sprinkler system gauges and control valve inspections, and required maintenance for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0712 SS=F Bldg. 03	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 provide quarterly fire drill documentation for 3 of 3 shifts during 2 of 4 quarters. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's fire drill reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility	K 0712	**K 712** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. Fire drills have been conducted on both shifts (Days, Nights) in all 8 villas. Documentation is readily available.	06/19/2023

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	lacked fire drill documentation for the following shifts and quarters during the past 12 month period: a. First shift (day) of the first quarter (January, February, and March) of 2023 b. Second shift (evening) of the second quarter (April, May, and June) of 2022 and so far in 2023 c. Third shift (night) of the first quarter (January, February, and March) of 2023 Based on interview at the time of record review, the Maintenance Director confirmed the lack of fire drill reports during the previously mentioned shifts and quarters. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to provide complete fire drill documentation for 1 of 9 fire drills performed during the past 12 month period. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the documented fire drill report performed on 03/28/23 (second shift of the first quarter) did not include the names and signatures of staff that participated in the fire drill. Based on interview at the time of record review, the Maintenance Director confirmed the lack of staff signatures on the fire drill report dated 03/28/23. This finding was reviewed with the Executive		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff and visitors have the potential to be affected by the alleged deficient practice. Fire drills have been conducted on both shifts (Days, Nights) at expected and unexpected times under various conditions in all 8 villas. Documentation includes employee signatures that participated in each drill and transmission of the alarm that was received by monitoring company. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the requirements of conducting monthly fire drills in all 8 Villas on both day shift and night shift at expected and unexpected times under various conditions and the required documentation of those that participated in the drills and transmission of the alarm that was received by the monitoring company. The administrator/designee will complete a Performance Improvement Tool to ensure the monthly fire drills were conducted	

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	Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 3 of 9 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, fire drill reports dated 08/27/22, 10/27/22 and 03/28/23 were not provided with documentation for the transmission of the alarm to the monitoring company. Based on interview at the time of record review, the Maintenance Director acknowledged there was no information on the previously mentioned fire drill reports to verify that transmission of the alarm was received by the monitoring company. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3-1.19(b)		at expected and unexpected times under various conditions monthly on both shifts and validate proper documentation is completed. Non-compliance with required fire drills and documentation will result in disciplinary action up to and including termination **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to the competition and proper documentation of the required fire drills for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0914 SS=F Bldg. 03	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and			

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	Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)			
	Based on observation, record review and interview; the facility failed to ensure complete documentation was available for all nonhospital-grade electrical receptacles in all resident room locations 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	K 0914	**K 914** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. Non-hospital grade receptacles in resident rooms have been tested for polarity, continuity of ground circuit, and retention force of grounding blade. Receptacles were replaced as indicated by the tests.	06/19/2023

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	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 record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available of an annual resident room receptacle test for non hospital-grade receptacles. Based on interview at the time of record review, the Maintenance Director said all of the electrical receptacles in resident rooms were not hospital-grade receptacles as far as he knew. He further said he has been the Maintenance Director at the facility for only four months and could not find documentation to show that annual testing per NFPA 99, Receptacle Testing requirements was met with all pertinent information within the past 12 month period or prior. Based on observations on 05/11/23 between 10:00 a.m. and 12:00 p.m. during a tour of the facility with the Maintenance Director, there were at least four electrical receptacles in each resident room. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff and visitors have the potential to be affected by the alleged deficient practice. Non-hospital grade receptacles in resident rooms have been tested for polarity, continuity of ground circuit, and retention force of grounding blade. Receptacles were replaced as indicated by the tests. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director was educated on documenting the annual testing of non-hospital grade receptacles in resident rooms, to include testing for polarity, continuity of ground circuit, and retention force of the grounding blade. Receptacles were replaced as indicated by the tests. The administrator/designee will complete a Performance Improvement Tool to ensure non-hospital grade receptacles are tested annually, replace when indicated by testing, and required documentation. Non-compliance with required annual test will result in disciplinary action up to and	

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			including termination **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to testing non-hospital grade receptacles annually for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0000 Bldg. 04	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 Dates: 05/10/23 and 05/11/23 Facility Number: 011509 Provider Number: 155770 AIM Number: 200909280 At this Life Safety Code survey, Villas of Guerin Woods, 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	K 0000	**Plan of Correction for the Villas of Guerin Woods 2023 Life Safety Code with Emergency Preparedness Survey.** **The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation**. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in	

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	National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. Villa 1003 was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 10 and had a census of 9 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 05/17/23		lieu of the Post Survey Revisit.	
K 0291 SS=F Bldg. 04	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review, observation, and interview; the facility failed to ensure there was documentation for the testing of 5 of 5 battery backup lights that were tested monthly for 30 seconds during 6 of the past 12 months, and annually for 90 minutes during the past 12 months to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be	K 0291	**K 291** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. All 5 of the facilities battery backup lights that were tested for 90 minutes and documented accordingly. **How will you identify other**	06/19/2023

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	conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility did have a preventative maintenance (PM) report that battery powered emergency lights were tested monthly, however, there was no 30 second monthly testing documentation since 09/26/22. Furthermore, there was no documentation available to show the five battery powered emergency lights were tested annually for 90 minutes. Based on an interview at the time of record review, the Maintenance Director agreed the PM form for the battery powered emergency lights did not include 30 second monthly testing for each battery powered light since 09/26/22. Furthermore, he said there was no documentation available for an annual 90 minute test during the past 12 month period. During a tour of the facility with the Maintenance Director on 05/11/23 between 10:00 a.m. and 12:00 p.m., the facility was equipped with five emergency battery powered lights. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		**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 alleged deficient practice. All 5 of the facilities' battery backup lights were tested for 90 minutes and documented accordingly. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the NFPA's emergency battery backup lighting's testing requirements. The 5 battery backup lights will be tested monthly by the maintenance director/designee for 30 seconds and 90 minutes annually with completed documentation. The administrator/designee will complete a Performance Improvement Tool monthly for 6 months after reviewing the monthly testing report to ensure the light will provide lighting during a power outage. Non-compliance with emergency battery backup lighting testing will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			deficient practice will not recur, i.e., what quality assurance program will be put into place? The Quality Assurance Committee will review Performance Improvement Tool related to emergency battery backup lighting's monthly testing for compliance and further recommendations during the scheduled monthly meeting. . **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0345 SS=F Bldg. 04	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. Based on record review and interview, the facility failed to ensure the annual testing of all devices connected to 1 of 1 fire alarm system was performed. NFPA 72, National Fire Alarm Code, the 2010 Edition, at 14.6.2.4 requires a record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 14.6.2.4:	K 0345	**K 345** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. The	06/19/2023

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	(1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency (ies) (7) Designation of the detector(s) tested (8) Functional test of detectors (9)*Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Functional test of mass notification system control units (13) Functional test of signal transmission to mass notification systems (14) Functional test of ability of mass notification system to silence fire alarm notification appliances (15) Tests of intelligibility of mass notification system speakers (16) Other tests as required by the equipment manufacturer's published instructions (17) Other tests as required by the authority having jurisdiction (18) Signatures of tester and approved authority representative (19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place) This deficient practice could affect all occupants in the facility. Findings include:		components of the identified Fire Alarm System have been tested, calibrated as needed, and inspected per the NFPA 70, National, Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff, and visitors have the potential to be affected by the alleged deficient practice. The facilities other Fire Alarm Systems have been tested, calibrated as needed, and inspected per the NFPA 70, National, Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on testing and maintenance of a fire alarm system accordance with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code and that documentation is readily available for review. The administrator/designee will	

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	Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility was able to provide a semi-annual visual fire alarm system inspection report dated 06/24/22 performed by the facility's maintenance staff, however, there was no documentation available for an annual visual inspection and functional test of all devices connected to the fire alarm system. Based on interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure documentation was available to show that all smoke detectors were sensitivity tested within the past 24 months or prior. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method.		complete a Performance Improvement Tool monthly to ensure the testing, recalibration as needed, and inspections are completed per regulations. Non-compliance with required testing, calibration, and inspection will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to Fire Alarm Systems for compliance and for further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	

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	(2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility was unable to produce a smoke detector sensitivity report for all smoke detectors for the past 24 month period. Based on interview at the time of record review, the Maintenance Director confirmed there was no smoke detector sensitivity testing documentation available for the past 24 months. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)			
K 0353 SS=F Bldg. 04	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing			

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	Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 dry sprinkler system during 41 of the past 52 weeks. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility.	K 0353	**E 353** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The identified facility's dry sprinkler system gauges and control valve were inspected, and maintenance performed as indicated. The documentation is readily available. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff, and visitors have the potential to be affected by the alleged deficient practice. An audit was completed on the	06/19/2023

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	Findings include: a. Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available to show the facility's dry sprinkler system gauges were inspected weekly during 41 of the past 52 week period. Based on interview at the time of record review, the Maintenance Director confirmed there was no documentation available to show that the facility's sprinkler gauges have been inspected at least weekly during 41 of the past 52 weeks. Based on observations with the Maintenance Director during a tour of the facility on 05/11/23 between 10:00 a.m. and 12:00 p.m. the facility had three pressure gauges at the sprinkler riser. b. Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no monthly sprinkler system control valves inspection documentation for 8 of the past 12 months. Based on interview at the time of record review, the Maintenance Director confirmed the lack of sprinkler system inspections on the control valves during the past 12 months. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		remainder Villas to identify sprinkler system gauges and control valve were not inspected and lacking maintenance as required. The identified areas were corrected. The documentation is readily available. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the facility's dry sprinkler system gauges, control valves, required inspections, and maintenance. The administrator/designee will complete a Performance Improvement Tool after reviewing the monthly documentation of the weekly and monthly inspections and maintenance that is performed as required. Non-compliance of the required weekly and monthly inspections and required maintenance will result in disciplinary action up to and including termination **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to	

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			sprinkler system gauges and control valve inspections, and required maintenance for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0712 SS=F Bldg. 04	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 provide quarterly fire drill documentation for 3 of 3 shifts during 2 of 4 quarters. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's fire drill reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility lacked fire drill documentation for the following shifts and quarters during the past 12 month period:	K 0712	**K 712** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. Fire drills have been conducted on both shifts (Days, Nights) in all 8 villas. Documentation is readily available. **How will you identify other residents having the potential**	06/19/2023

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	a. Second shift (evening) of the first quarter (January, February, and March) of 2023, and second quarter (April, May, and June) of 2022 and so far in 2023 b. Third shift (night) of the first quarter (January, February, and March) of 2023 Based on interview at the time of record review, the Maintenance Director confirmed the lack of fire drill reports during the previously mentioned shifts and quarters. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to provide complete fire drill documentation for 1 of 9 fire drills performed during the past 12 month period. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the documented fire drill report performed on 03/28/23 (first shift of the first quarter) did not include the names and signatures of staff that participated in the fire drill. Based on interview at the time of record review, the Maintenance Director confirmed the lack of staff signatures on the fire drill report dated 03/28/23. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23.		**to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff and visitors have the potential to be affected by the alleged deficient practice. Fire drills have been conducted on both shifts (Days, Nights) at expected and unexpected times under various conditions in all 8 villas. Documentation includes employee signatures that participated in each drill and transmission of the alarm that was received by monitoring company. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the requirements of conducting monthly fire drills in all 8 Villas on both day shift and night shift at expected and unexpected times under various conditions and the required documentation of those that participated in the drills and transmission of the alarm that was received by the monitoring company. The administrator/designee will complete a Performance Improvement Tool to ensure the monthly fire drills were conducted at expected and unexpected times under various conditions monthly on both shifts and validate proper	

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	3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 3 of 9 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, fire drill reports dated 08/27/22, 10/27/22 and 03/28/23 were not provided with documentation for the transmission of the alarm to the monitoring company. Based on interview at the time of record review, the Maintenance Director acknowledged there was no information on the previously mentioned fire drill reports to verify that transmission of the alarm was received by the monitoring company. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3-1.19(b)		documentation is completed. Non-compliance with required fire drills and documentation will result in disciplinary action up to and including termination **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to the competition and proper documentation of the required fire drills for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0914 SS=F Bldg. 04	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general			

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	anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)			
	Based on observation, record review and interview; the facility failed to ensure complete documentation was available for all nonhospital-grade electrical receptacles in all resident room locations 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	K 0914	**K 914** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. Non-hospital grade receptacles in resident rooms have been tested for polarity, continuity of ground circuit, and retention force of grounding blade. Receptacles were replaced as indicated by the tests. **How will you identify other residents having the potential**	06/19/2023

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	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 record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available of an annual resident room receptacle test for non hospital-grade receptacles. Based on interview at the time of record review, the Maintenance Director said all of the electrical receptacles in resident rooms were not hospital-grade receptacles as far as he knew. He further said he has been the Maintenance Director at the facility for only four months and could not find documentation to show that annual testing per NFPA 99, Receptacle Testing requirements was met with all pertinent information within the past 12 month period or prior. Based on observations on 05/11/23 between 10:00 a.m. and 12:00 p.m. during a tour of the facility with the Maintenance Director, there were at least four electrical receptacles in each resident room. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		**to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff and visitors have the potential to be affected by the alleged deficient practice. Non-hospital grade receptacles in resident rooms have been tested for polarity, continuity of ground circuit, and retention force of grounding blade. Receptacles were replaced as indicated by the tests. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director was educated on documenting the annual testing of non-hospital grade receptacles in resident rooms, to include testing for polarity, continuity of ground circuit, and retention force of the grounding blade. Receptacles were replaced as indicated by the tests. The administrator/designee will complete a Performance Improvement Tool to ensure non-hospital grade receptacles are tested annually, replace when indicated by testing, and required documentation. Non-compliance with required annual test will result in disciplinary action up to and including termination **How the corrective action (s)**	

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			will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Quality Assurance Committee will review the Performance Improvement Tool related to testing non-hospital grade receptacles annually for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0918 SS=F Bldg. 04	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			

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	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, 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 ensure a written record of weekly inspections for 1 of 1 generator was maintained for 31 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include:	K 0918	**K 918** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. The facilities five generators have the require weekly inspections/tested, monthly load toad test, annual maintenance, and 4-hour load test completed and documented according to meet NFPA emergency power and standby system requirements. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff, and visitors have the potential to be affected	06/19/2023

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	155770	A. BUILDING 04 B. WING	05/11/2023

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	Based on review of the generator inspection reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available to show the emergency generator was inspected/tested weekly during 31 of the most recent 52 week period (nothing since 10/03/22). Based on interview at the time of record review, the Maintenance Director said he does test/inspect of the emergency generator weekly but does not always document the test/inspection results. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 6 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications.		by the alleged deficient practice. The facilities five generators have the require weekly inspections/tested, monthly load toad test, annual maintenance, and 4-hour load test completed and documented according to meet NFPA emergency power and standby system requirements. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the NFPA's LTC emergency and standby power system requirements. The administrator/designee will complete the Performance Improvement Tool for 6 months after reviewing the weekly inspections/testing documentation weekly, the monthly load toad test documentation during the scheduled monthly Quality Assurance meeting and the annual maintenance and 4-hour load test documentation during each Decembers scheduled QA meeting to ensure the requirements are met. This practice will be ongoing. Non-compliance of weekly inspections/testing documentation weekly, the monthly load toad test documentation will result in disciplinary action up to and including termination.	

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	8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no monthly generator load test documentation available for 6 of the past 12 months (nothing since 09/26/22) for the emergency generator. Based on interview at the time of record review, the Maintenance Director confirmed there was no emergency generator load test documentation for 6 of the past 12 months for the emergency generator. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 3. Based on record review and interview, the facility failed to ensure a written record of routine maintenance and testing for 1 of 1 emergency generator was maintained and available. NFPA 110, the Standard for Emergency and Standby Powers Systems, at 8.3.3 requires a written schedule for routine maintenance and operational testing of the EPSS shall be established. 8.3.4 requires a permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available.		**How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related emergency and standby power system requirements for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	

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	8.3.4.1 requires the permanent record shall include the following: (1) The date of the maintenance report (2) Identification of the servicing personnel (3) Notification of any unsatisfactory condition and the corrective action taken, including parts replaced (4) Testing of any repair for the time as recommended by the manufacturer. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available to show that the emergency generator has had routine maintenance during the past 12 months. Based on interview at the time of record review, the Maintenance Director said he has been the Maintenance Director at the facility for only four months and has not seen evidence/documentation that routine maintenance has been performed on the generator either in house or from an outside vendor. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 4. Based on record review and interview, the facility failed to provide complete documentation for the testing of 5 of 5 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			

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	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. NFPA 110, Section 8.4.9.5.3 states for spark-ignited (LP or Natural Gas) EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility could not provide documentation of a four hour load test of the LP gas fueled emergency generator within the past 36 months for the five emergency generators. This was confirmed by the Maintenance Director at the time of record review. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)			
K 0923 SS=F Bldg. 04	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior			

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	space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 2 smoke compartments. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.3 states storage for nonflammable gases with a total volume equal to or less than greater than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1	K 0923	**K 923** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged	06/19/2023

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	and 11.3.3.2. NFPA 99, Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations on 05/11/23 between 10:00 a.m. and 12:00 p.m. during a tour of the facility with the Maintenance Director, there was one medium sized oxygen cylinder freestanding on the floor in resident room 5. The oxygen cylinder was not supported in a proper cylinder stand or otherwise secured from falling. Based on interview at the time of the observation, the Maintenance Director acknowledged the oxygen cylinder freestanding on the floor in resident room 5 and not supported in a cylinder stand or otherwise secured from falling. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		deficient practice. Oxygen cylinders have been placed in proper carts and secured with the thumb screw. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff and visitors have the potential to be affected by the alleged deficient practice. An audit was conducted to identify oxygen cylinders that were not properly secured. The identified unsecured cylinders were secured immediately. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on securing oxygen cylinders in the proper cylinder stand and will complete environmental rounds in all 8 Villas 5 days a week for 4 weeks and then weekly x 5 months to ensure oxygen cylinders are being safely secured. The administrator will complete a Performance Improvement Tool after reviewing the environmental round sheets weekly for 6 months to ensure compliance. Non-compliance with daily environmental rounds will result in disciplinary action up to	

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			and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance improvement Tool for compliance and to make further recommendations. By what date will the systemic changes for each deficiency be completed? 6/19/2023	
K 0000 Bldg. 05	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 Dates: 05/10/23 and 05/11/23 Facility Number: 011509 Provider Number: 155770 AIM Number: 200909280 At this Life Safety Code survey, Villas of Guerin Woods, 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), and 410 IAC 16.2. Villa 1005 was surveyed with Chapter 19, Existing Health Care Occupancies.	K 0000	**Plan of Correction for the Villas of Guerin Woods 2023 Life Safety Code with Emergency Preparedness Survey.** **The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation**. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of the Post Survey Revisit.	

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	This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 10 and had a census of 9 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 05/17/23			
K 0291 SS=F Bldg. 05	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review, observation, and interview; the facility failed to ensure there was documentation for the testing of 5 of 5 battery backup lights that were tested monthly for 30 seconds during 6 of the past 12 months, and annually for 90 minutes during the past 12 months to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner	K 0291	**K 291** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. All 5 of the facilities battery backup lights that were tested for 90 minutes and documented accordingly. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	06/19/2023

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	for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility did have a preventative maintenance (PM) report that battery powered emergency lights were tested monthly, however, there was no 30 second monthly testing documentation since 09/26/22. Furthermore, there was no documentation available to show the five battery powered emergency lights were tested annually for 90 minutes. Based on an interview at the time of record review, the Maintenance Director agreed the PM form for the battery powered emergency lights did not include 30 second monthly testing for each battery powered light since 09/26/22. Furthermore, he said there was no documentation available for an annual 90 minute test during the past 12 month period. During a tour of the facility with the Maintenance Director on 05/11/23 between 10:00 a.m. and 12:00 p.m., the facility was equipped with five emergency battery powered lights. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		All residents have the potential to be affected by the alleged deficient practice. All 5 of the facilities' battery backup lights were tested for 90 minutes and documented accordingly. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the NFPA's emergency battery backup lighting's testing requirements. The 5 battery backup lights will be tested monthly by the maintenance director/designee for 30 seconds and 90 minutes annually with completed documentation. The administrator/designee will complete a Performance Improvement Tool monthly for 6 months after reviewing the monthly testing report to ensure the light will provide lighting during a power outage. Non-compliance with emergency battery backup lighting testing will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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			The Quality Assurance Committee will review Performance Improvement Tool related to emergency battery backup lighting's monthly testing for compliance and further recommendations during the scheduled monthly meeting. . **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0324 SS=C Bldg. 05	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review and interview, the facility	K 0324	**E 324**	06/19/2023

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	failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the only inspection documentation available during the past twelve months for the range hood exhaust system was dated 04/20/23.		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. The kitchen exhaust system in the identified Villa has been inspected and cleaned. **How will you 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 alleged deficient practice. The kitchen exhaust systems in the other 7 villas have been inspected and cleaned if indicated by the inspection. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations requirements as related to required inspections and cleaning of the ventilation system. The inspection will be scheduled by the maintenance director/designee for monthly and annual inspections/cleaning. The	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	There was no range hood exhaust system inspection report available within six months prior to the 04/20/23 date. Based on interview at the time of record review, the Maintenance Director said he could not find a range hood exhaust system inspection within six months prior to the 04/20/23 date. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		administrator/designee will complete a Performance Improvement Tool monthly to ensure the inspections were completed and the findings were addressed as needed. Non-compliance with required testing inspections and cleanings will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to kitchen ventilation inspections for compliance and to make further recommendations as needed. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0345 SS=F Bldg. 05	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			

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	155770	A. BUILDING 05 B. WING	05/11/2023

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	1. Based on record review and interview, the facility failed to ensure the annual testing of all devices connected to 1 of 1 fire alarm system was performed. NFPA 72, National Fire Alarm Code, the 2010 Edition, at 14.6.2.4 requires a record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 14.6.2.4: (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency (ies) (7) Designation of the detector(s) tested (8) Functional test of detectors (9)*Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Functional test of mass notification system control units (13) Functional test of signal transmission to mass notification systems (14) Functional test of ability of mass notification system to silence fire alarm notification appliances (15) Tests of intelligibility of mass notification system speakers (16) Other tests as required by the equipment manufacturer's published instructions (17) Other tests as required by the authority having jurisdiction (18) Signatures of tester and approved authority representative	K 0345	**K 345** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. The components of the identified Fire Alarm System have been tested, calibrated as needed, and inspected per the NFPA 70, National, Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff, and visitors have the potential to be affected by the alleged deficient practice. The facilities other Fire Alarm Systems have been tested, calibrated as needed, and inspected per the NFPA 70, National, Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on testing and	06/19/2023

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	(19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place) This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility was able to provide a semi-annual visual fire alarm system inspection report dated 06/24/22 performed by the facility's maintenance staff, however, there was no documentation available for an annual visual inspection and functional test of all devices connected to the fire alarm system. Based on interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure documentation was available to show that all smoke detectors were sensitivity tested within the past 24 months or prior. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of		maintenance of a fire alarm system accordance with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code and that documentation is readily available for review. The administrator/designee will complete a Performance Improvement Tool monthly to ensure the testing, recalibration as needed, and inspections are completed per regulations. Non-compliance with required testing, calibration, and inspection will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to Fire Alarm Systems for compliance and for further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	

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	5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility was unable to produce a smoke detector sensitivity report for all smoke detectors for the past 24 month period. Based on interview at the time of record review, the Maintenance Director confirmed there was no smoke detector sensitivity testing documentation available for the past 24 months.			

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	This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)			
K 0353 SS=F Bldg. 05	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 dry sprinkler system during 41 of the past 52 weeks. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter	K 0353	**E 353** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The identified facility's dry sprinkler system gauges and control valve were inspected, and maintenance performed as indicated. The documentation is readily available.	06/19/2023

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	13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: a. Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available to show the facility's dry sprinkler system gauges were inspected weekly during 41 of the past 52 week period. Based on interview at the time of record review, the Maintenance Director confirmed there was no documentation available to show that the facility's sprinkler gauges have been inspected at least weekly during 41 of the past 52 weeks. Based on observations with the Maintenance Director during a tour of the facility on 05/11/23 between 10:00 a.m. and 12:00 p.m. the facility had three pressure gauges at the sprinkler riser. b. Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no monthly sprinkler system control valves inspection documentation for 8 of the past 12 months. Based on interview at the time of record review, the Maintenance Director confirmed the lack of sprinkler system inspections on the control valves during the past 12 months. This finding was reviewed with the Executive Director and Maintenance Director during the exit		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff, and visitors have the potential to be affected by the alleged deficient practice. An audit was completed on the remainder Villas to identify sprinkler system gauges and control valve were not inspected and lacking maintenance as required. The identified areas were corrected. The documentation is readily available. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the facility's dry sprinkler system gauges, control valves, required inspections, and maintenance. The administrator/designee will complete a Performance Improvement Tool after reviewing the monthly documentation of the weekly and monthly inspections and maintenance that is performed as required. Non-compliance of the required weekly and monthly inspections and required maintenance will result in disciplinary action up to and including termination	

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	conference on 05/11/23. 3.1-19(b)		**How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to sprinkler system gauges and control valve inspections, and required maintenance for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0712 SS=F Bldg. 05	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 provide quarterly fire drill documentation for 3 of 3 shifts during 2 of 4 quarters. This deficient practice could affect all residents, as well as staff and visitors in the facility.	K 0712	**K 712** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	06/19/2023

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	Findings include: Based on review of the facility's fire drill reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility lacked fire drill documentation for the following shifts and quarters during the past 12 month period: a. Second shift (evening) of the first quarter (January, February, and March) of 2023, and second quarter (April, May, and June) of 2022 and so far in 2023 b. Third shift (night) of the first quarter (January, February, and March) of 2023 Based on interview at the time of record review, the Maintenance Director confirmed the lack of fire drill reports during the previously mentioned shifts and quarters. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to provide complete fire drill documentation for 1 of 9 fire drills performed during the past 12 month period. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the documented fire drill report performed on 03/28/23 (first shift of the first quarter) did not include the names and signatures of staff that participated in		No residents were found to have been affected by this alleged deficient practice. Fire drills have been conducted on both shifts (Days, Nights) in all 8 villas. Documentation is readily available. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff and visitors have the potential to be affected by the alleged deficient practice. Fire drills have been conducted on both shifts (Days, Nights) at expected and unexpected times under various conditions in all 8 villas. Documentation includes employee signatures that participated in each drill and transmission of the alarm that was received by monitoring company. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the requirements of conducting monthly fire drills in all 8 Villas on both day shift and night shift at expected and unexpected times under various conditions and the required documentation of those that participated in the drills and transmission of the alarm that was	

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	the fire drill. Based on interview at the time of record review, the Maintenance Director confirmed the lack of staff signatures on the fire drill report dated 03/28/23. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 3 of 9 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, fire drill reports dated 08/27/22, 10/27/22 and 03/28/23 were not provided with documentation for the transmission of the alarm to the monitoring company. Based on interview at the time of record review, the Maintenance Director acknowledged there was no information on the previously mentioned fire drill reports to verify that transmission of the alarm was received by the monitoring company. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23.		received by the monitoring company. The administrator/designee will complete a Performance Improvement Tool to ensure the monthly fire drills were conducted at expected and unexpected times under various conditions monthly on both shifts and validate proper documentation is completed. Non-compliance with required fire drills and documentation will result in disciplinary action up to and including termination **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to the competition and proper documentation of the required fire drills for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	

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	3-1.19(b)			
K 0914 SS=F Bldg. 05	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and interview; the facility failed to ensure complete documentation was available for all nonhospital-grade electrical receptacles in all resident room locations 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	K 0914	**K 914** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. Non-hospital grade receptacles in resident	06/19/2023

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	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 record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available of an annual resident room receptacle test for non hospital-grade receptacles. Based on interview at the time of record review, the Maintenance Director said all of the electrical receptacles in resident rooms were not hospital-grade receptacles as far as he knew. He further said he has been the Maintenance Director at the facility for only four months and could not find documentation to show that annual testing per NFPA 99, Receptacle Testing requirements was met with all pertinent information within the past 12 month period or prior. Based on observations on 05/11/23 between 10:00 a.m. and 12:00 p.m. during a tour of the facility with the Maintenance Director, there were at least four electrical receptacles in each resident room. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23.		rooms have been tested for polarity, continuity of ground circuit, and retention force of grounding blade. Receptacles were replaced as indicated by the tests. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff and visitors have the potential to be affected by the alleged deficient practice. Non-hospital grade receptacles in resident rooms have been tested for polarity, continuity of ground circuit, and retention force of grounding blade. Receptacles were replaced as indicated by the tests. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director was educated on documenting the annual testing of non-hospital grade receptacles in resident rooms, to include testing for polarity, continuity of ground circuit, and retention force of the grounding blade. Receptacles were replaced as indicated by the tests. The administrator/designee will complete a Performance Improvement Tool to ensure	

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	3.1-19(b)		non-hospital grade receptacles are tested annually, replace when indicated by testing, and required documentation. Non-compliance with required annual test will result in disciplinary action up to and including termination **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to testing non-hospital grade receptacles annually for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0918 SS=F Bldg. 05	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			

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	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, 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 ensure a written record of weekly inspections for 1 of 1 generator was maintained for 31 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a	K 0918	**K 918** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. The facilities five generators have the require weekly inspections/tested, monthly load toad test, annual maintenance, and 4-hour load test completed and documented according to meet NFPA emergency power and	06/19/2023

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	155770	A. BUILDING 05 B. WING	05/11/2023

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	written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available to show the emergency generator was inspected/tested weekly during 31 of the most recent 52 week period (nothing since 10/03/22). Based on interview at the time of record review, the Maintenance Director said he does test/inspect of the emergency generator weekly but does not always document the test/inspection results. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 6 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having		standby system requirements. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff, and visitors have the potential to be affected by the alleged deficient practice. The facilities five generators have the require weekly inspections/tested, monthly load toad test, annual maintenance, and 4-hour load test completed and documented according to meet NFPA emergency power and standby system requirements. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the NFPA's LTC emergency and standby power system requirements. The administrator/designee will complete the Performance Improvement Tool for 6 months after reviewing the weekly inspections/testing documentation weekly, the monthly load toad test documentation during the scheduled monthly Quality Assurance meeting and the annual maintenance and 4-hour load test documentation during each Decembers scheduled QA	

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	jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no monthly generator load test documentation available for 6 of the past 12 months (nothing since 09/26/22) for the emergency generator. Based on interview at the time of record review, the Maintenance Director confirmed there was no emergency generator load test documentation for 6 of the past 12 months for the emergency generator. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 3. Based on record review and interview, the facility failed to ensure a written record of routine		meeting to ensure the requirements are met. This practice will be ongoing. Non-compliance of weekly inspections/testing documentation weekly, the monthly load toad test documentation will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related emergency and standby power system requirements for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	

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	maintenance and testing for 1 of 1 emergency generator was maintained and available. NFPA 110, the Standard for Emergency and Standby Powers Systems, at 8.3.3 requires a written schedule for routine maintenance and operational testing of the EPSS shall be established. 8.3.4 requires a permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. 8.3.4.1 requires the permanent record shall include the following: (1) The date of the maintenance report (2) Identification of the servicing personnel (3) Notification of any unsatisfactory condition and the corrective action taken, including parts replaced (4) Testing of any repair for the time as recommended by the manufacturer. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available to show that the emergency generator has had routine maintenance during the past 12 months. Based on interview at the time of record review, the Maintenance Director said he has been the Maintenance Director at the facility for only four months and has not seen evidence/documentation that routine maintenance has been performed on the generator either in house or from an outside vendor. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)			

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	4. Based on record review and interview, the facility failed to provide complete documentation for the testing of 5 of 5 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. NFPA 110, Section 8.4.9.5.3 states for spark-ignited (LP or Natural Gas) EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility could not provide documentation of a four hour load test of the LP gas fueled emergency generator within the past 36 months for the five emergency generators. This was confirmed by the Maintenance Director at the time of record review. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)			
K 0000 Bldg. 06				

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	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 Dates: 05/10/23 and 05/11/23 Facility Number: 011509 Provider Number: 155770 AIM Number: 200909280 At this Life Safety Code survey, Villas of Guerin Woods, 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), and 410 IAC 16.2. Villa 1006 was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 10 and had a census of 9 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 05/17/23	K 0000	**Plan of Correction for the Villas of Guerin Woods 2023 Life Safety Code with Emergency Preparedness Survey.** **The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation**. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of the Post Survey Revisit.	
K 0291 SS=F Bldg. 06	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in			

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	accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review, observation, and interview; the facility failed to ensure there was documentation for the testing of 5 of 5 battery backup lights that were tested monthly for 30 seconds during 6 of the past 12 months, and annually for 90 minutes during the past 12 months to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility did have a preventative maintenance (PM) report that battery powered emergency lights were tested monthly, however, there was no 30 second monthly testing documentation since 09/26/22. Furthermore, there was no documentation available to show the five battery powered emergency lights were tested annually for 90 minutes. Based on an interview at the time of record review, the Maintenance Director agreed the PM form for the battery powered emergency lights did not include 30	K 0291	**K 291** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. All 5 of the facilities battery backup lights that were tested for 90 minutes and documented accordingly. **How will you 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 alleged deficient practice. All 5 of the facilities' battery backup lights were tested for 90 minutes and documented accordingly. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the NFPA's emergency battery backup lighting's testing requirements. The 5 battery backup lights will be tested monthly by the maintenance director/designee for 30 seconds and 90 minutes	06/19/2023

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	second monthly testing for each battery powered light since 09/26/22. Furthermore, he said there was no documentation available for an annual 90 minute test during the past 12 month period. During a tour of the facility with the Maintenance Director on 05/11/23 between 10:00 a.m. and 12:00 p.m., the facility was equipped with five emergency battery powered lights. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		annually with completed documentation. The administrator/designee will complete a Performance Improvement Tool monthly for 6 months after reviewing the monthly testing report to ensure the light will provide lighting during a power outage. Non-compliance with emergency battery backup lighting testing will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review Performance Improvement Tool related to emergency battery backup lighting's monthly testing for compliance and further recommendations during the scheduled monthly meeting. . **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0345 SS=F Bldg. 06	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained			

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	in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. Based on record review and interview, the facility failed to ensure the annual testing of all devices connected to 1 of 1 fire alarm system was performed. NFPA 72, National Fire Alarm Code, the 2010 Edition, at 14.6.2.4 requires a record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 14.6.2.4: (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency (ies) (7) Designation of the detector(s) tested (8) Functional test of detectors (9)*Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Functional test of mass notification system control units (13) Functional test of signal transmission to mass notification systems (14) Functional test of ability of mass notification system to silence fire alarm notification appliances (15) Tests of intelligibility of mass notification	K 0345	**K 345** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. The components of the identified Fire Alarm System have been tested, calibrated as needed, and inspected per the NFPA 70, National, Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff, and visitors have the potential to be affected by the alleged deficient practice. The facilities other Fire Alarm Systems have been tested, calibrated as needed, and inspected per the NFPA 70, National, Electric Code, and NFPA 72, National Fire Alarm and Signaling Code.	06/19/2023

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	system speakers (16) Other tests as required by the equipment manufacturer's published instructions (17) Other tests as required by the authority having jurisdiction (18) Signatures of tester and approved authority representative (19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place) This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility was able to provide a semi-annual visual fire alarm system inspection report dated 06/24/22 performed by the facility's maintenance staff, however, there was no documentation available for an annual visual inspection and functional test of all devices connected to the fire alarm system. Based on interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure documentation was available to show that all smoke detectors were sensitivity tested within the past 24 months or prior. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on testing and maintenance of a fire alarm system accordance with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code and that documentation is readily available for review. The administrator/designee will complete a Performance Improvement Tool monthly to ensure the testing, recalibration as needed, and inspections are completed per regulations. Non-compliance with required testing, calibration, and inspection will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to Fire Alarm Systems for compliance and for further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	

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	sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility was unable to produce a			

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	smoke detector sensitivity report for all smoke detectors for the past 24 month period. Based on interview at the time of record review, the Maintenance Director confirmed there was no smoke detector sensitivity testing documentation available for the past 24 months. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)			
K 0353 SS=F Bldg. 06	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 dry sprinkler system during 41 of the past 52 weeks. NFPA 25, Standard for the Inspection, Testing, and Maintenance of	K 0353	**E 353** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	06/19/2023

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	Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: a. Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available to show the facility's dry sprinkler system gauges were inspected weekly during 41 of the past 52 week period. Based on interview at the time of record review, the Maintenance Director confirmed there was no documentation available to show that the facility's sprinkler gauges have been inspected at least weekly during 41 of the past 52 weeks. Based on observations with the Maintenance Director during a tour of the facility on 05/11/23 between 10:00 a.m. and 12:00 p.m. the facility had three pressure gauges at the sprinkler riser. b. Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no monthly sprinkler system control valves inspection documentation for 8 of the past 12 months. Based on interview at		The identified facility's dry sprinkler system gauges and control valve were inspected, and maintenance performed as indicated. The documentation is readily available. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff, and visitors have the potential to be affected by the alleged deficient practice. An audit was completed on the remainder Villas to identify sprinkler system gauges and control valve were not inspected and lacking maintenance as required. The identified areas were corrected. The documentation is readily available. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the facility's dry sprinkler system gauges, control valves, required inspections, and maintenance. The administrator/designee will complete a Performance Improvement Tool after reviewing the monthly documentation of the weekly and monthly inspections and maintenance that is performed	

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	the time of record review, the Maintenance Director confirmed the lack of sprinkler system inspections on the control valves during the past 12 months. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		as required. Non-compliance of the required weekly and monthly inspections and required maintenance will result in disciplinary action up to and including termination **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to sprinkler system gauges and control valve inspections, and required maintenance for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0712 SS=F Bldg. 06	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.			

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	19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 3 of 3 shifts during 2 of 4 quarters. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's fire drill reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility lacked fire drill documentation for the following shifts and quarters during the past 12 month period: a. Second shift (evening) of the first quarter (January, February, and March) of 2023, and second quarter (April, May, and June) of 2022 and so far in 2023 b. Third shift (night) of the first quarter (January, February, and March) of 2023 Based on interview at the time of record review, the Maintenance Director confirmed the lack of fire drill reports during the previously mentioned shifts and quarters. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to provide complete fire drill documentation for 1 of 9 fire drills performed during the past 12 month period. This deficient practice could affect all residents in the facility. Findings include:	K 0712	**K 712** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. Fire drills have been conducted on both shifts (Days, Nights) in all 8 villas. Documentation is readily available. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff and visitors have the potential to be affected by the alleged deficient practice. Fire drills have been conducted on both shifts (Days, Nights) at expected and unexpected times under various conditions in all 8 villas. Documentation includes employee signatures that participated in each drill and transmission of the alarm that was received by monitoring company. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the requirements of conducting	06/19/2023

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	Based on review of the facility's fire drill reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the documented fire drill report performed on 03/28/23 (first shift of the first quarter) did not include the names and signatures of staff that participated in the fire drill. Based on interview at the time of record review, the Maintenance Director confirmed the lack of staff signatures on the fire drill report dated 03/28/23. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 3 of 9 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, fire drill reports dated 08/27/22, 10/27/22 and 03/28/23 were not provided with documentation for the transmission of the alarm to the monitoring company. Based on interview at the time of record review, the Maintenance Director acknowledged there was no information on the previously mentioned fire drill		monthly fire drills in all 8 Villas on both day shift and night shift at expected and unexpected times under various conditions and the required documentation of those that participated in the drills and transmission of the alarm that was received by the monitoring company. The administrator/designee will complete a Performance Improvement Tool to ensure the monthly fire drills were conducted at expected and unexpected times under various conditions monthly on both shifts and validate proper documentation is completed. Non-compliance with required fire drills and documentation will result in disciplinary action up to and including termination **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to the competition and proper documentation of the required fire drills for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	

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	reports to verify that transmission of the alarm was received by the monitoring company. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3-1.19(b)			
K 0914 SS=F Bldg. 06	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and interview; the facility failed to ensure complete documentation was available for all	K 0914	**K 914** **What corrective action(s) will be accomplished for those**	06/19/2023

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	nonhospital-grade electrical receptacles in all resident room locations 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 record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available of an annual resident room receptacle test for non hospital-grade receptacles. Based on interview at the time of record review, the Maintenance Director said all of the electrical receptacles in resident rooms were not hospital-grade receptacles as far as he knew. He further said he has been the Maintenance Director at the facility for only four months and could not find documentation to show that annual testing per NFPA 99, Receptacle Testing requirements was met with all pertinent information within the past 12 month period or prior. Based on observations on 05/11/23 between 10:00 a.m. and 12:00 p.m. during a tour of the facility with the Maintenance		**residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. Non-hospital grade receptacles in resident rooms have been tested for polarity, continuity of ground circuit, and retention force of grounding blade. Receptacles were replaced as indicated by the tests. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff and visitors have the potential to be affected by the alleged deficient practice. Non-hospital grade receptacles in resident rooms have been tested for polarity, continuity of ground circuit, and retention force of grounding blade. Receptacles were replaced as indicated by the tests. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director was educated on documenting the annual testing of non-hospital grade receptacles in resident rooms, to include testing for	

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	Director, there were at least four electrical receptacles in each resident room. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		polarity, continuity of ground circuit, and retention force of the grounding blade. Receptacles were replaced as indicated by the tests. The administrator/designee will complete a Performance Improvement Tool to ensure non-hospital grade receptacles are tested annually, replace when indicated by testing, and required documentation. Non-compliance with required annual test will result in disciplinary action up to and including termination **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to testing non-hospital grade receptacles annually for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0918 SS=F Bldg. 06	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			

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	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, 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 ensure a written record of weekly inspections for 1 of 1 generator was maintained for 31 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage	K 0918	**K 918** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged	06/19/2023

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	batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available to show the emergency generator was inspected/tested weekly during 31 of the most recent 52 week period (nothing since 10/03/22). Based on interview at the time of record review, the Maintenance Director said he does test/inspect of the emergency generator weekly but does not always document the test/inspection results. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 6 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency		deficient practice. The facilities five generators have the require weekly inspections/tested, monthly load toad test, annual maintenance, and 4-hour load test completed and documented according to meet NFPA emergency power and standby system requirements. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff, and visitors have the potential to be affected by the alleged deficient practice. The facilities five generators have the require weekly inspections/tested, monthly load toad test, annual maintenance, and 4-hour load test completed and documented according to meet NFPA emergency power and standby system requirements. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the NFPA's LTC emergency and standby power system requirements. The administrator/designee will complete the Performance Improvement Tool for 6 months after reviewing the weekly inspections/testing documentation	

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	electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no monthly generator load test documentation available for 6 of the past 12 months (nothing since 09/26/22) for the emergency generator. Based on interview at the time of record review, the Maintenance Director confirmed there was no emergency generator load test documentation for 6 of the past 12 months for the emergency generator. This finding was reviewed with the Executive		weekly, the monthly load toad test documentation during the scheduled monthly Quality Assurance meeting and the annual maintenance and 4-hour load test documentation during each Decembers scheduled QA meeting to ensure the requirements are met. This practice will be ongoing. Non-compliance of weekly inspections/testing documentation weekly, the monthly load toad test documentation will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related emergency and standby power system requirements for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	

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	Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 3. Based on record review and interview, the facility failed to ensure a written record of routine maintenance and testing for 1 of 1 emergency generator was maintained and available. NFPA 110, the Standard for Emergency and Standby Powers Systems, at 8.3.3 requires a written schedule for routine maintenance and operational testing of the EPSS shall be established. 8.3.4 requires a permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. 8.3.4.1 requires the permanent record shall include the following: (1) The date of the maintenance report (2) Identification of the servicing personnel (3) Notification of any unsatisfactory condition and the corrective action taken, including parts replaced (4) Testing of any repair for the time as recommended by the manufacturer. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available to show that the emergency generator has had routine maintenance during the past 12 months. Based on interview at the time of record review, the Maintenance Director said he has been the Maintenance Director at the facility for only four months and has not seen evidence/documentation that routine maintenance has been performed on the generator either in house or from an outside vendor.			

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	This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 4. Based on record review and interview, the facility failed to provide complete documentation for the testing of 5 of 5 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. NFPA 110, Section 8.4.9.5.3 states for spark-ignited (LP or Natural Gas) EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility could not provide documentation of a four hour load test of the LP gas fueled emergency generator within the past 36 months for the five emergency generators. This was confirmed by the Maintenance Director at the time of record review. This finding was reviewed with the Executive Director and Maintenance Director during the exit			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	conference on 05/11/23. 3.1-19(b)			
K 0000 Bldg. 07	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 Dates: 05/10/23 and 05/11/23 Facility Number: 011509 Provider Number: 155770 AIM Number: 200909280 At this Life Safety Code survey, Villas of Guerin Woods, 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), and 410 IAC 16.2. Villa 1007 was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 10 and had a census of 0 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.	K 0000	**Plan of Correction for the Villas of Guerin Woods 2023 Life Safety Code with Emergency Preparedness Survey.** **The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation**. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of the Post Survey Revisit.	

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	Quality Review completed on 05/17/23			
K 0291 SS=F Bldg. 07	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review, observation, and interview; the facility failed to ensure there was documentation for the testing of 5 of 5 battery backup lights that were tested monthly for 30 seconds during 6 of the past 12 months, and annually for 90 minutes during the past 12 months to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility did have a preventative maintenance (PM) report that battery powered emergency lights were tested monthly, however, there was no 30 second monthly testing	K 0291	**K 291** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. All 5 of the facilities battery backup lights that were tested for 90 minutes and documented accordingly. **How will you 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 alleged deficient practice. All 5 of the facilities' battery backup lights were tested for 90 minutes and documented accordingly. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has	06/19/2023

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	documentation since 09/26/22. Furthermore, there was no documentation available to show the five battery powered emergency lights were tested annually for 90 minutes. Based on an interview at the time of record review, the Maintenance Director agreed the PM form for the battery powered emergency lights did not include 30 second monthly testing for each battery powered light since 09/26/22. Furthermore, he said there was no documentation available for an annual 90 minute test during the past 12 month period. During a tour of the facility with the Maintenance Director on 05/11/23 between 10:00 a.m. and 12:00 p.m., the facility was equipped with five emergency battery powered lights. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		been educated on the NFPA's emergency battery backup lighting's testing requirements. The 5 battery backup lights will be tested monthly by the maintenance director/designee for 30 seconds and 90 minutes annually with completed documentation. The administrator/designee will complete a Performance Improvement Tool monthly for 6 months after reviewing the monthly testing report to ensure the light will provide lighting during a power outage. Non-compliance with emergency battery backup lighting testing will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review Performance Improvement Tool related to emergency battery backup lighting's monthly testing for compliance and further recommendations during the scheduled monthly meeting. . **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	

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K 0321 SS=F Bldg. 07	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) 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 1 egress corridor in 1 of 2 smoke compartments was not used to store combustible material. This deficient practice could affect all residents, staff, and visitors.	K 0321	**K 321** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	06/19/2023

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	Findings include: Based on observations on 05/11/23 between 10:00 a.m. and 12:00 p.m. during a tour of the facility with the Maintenance Director, the Beauty Shop area of the back hall was being used to store several plastic drawer type totes full of items, cardboard boxes, old furniture, and mattresses, and a variety of other storage items. This area was open to the egress corridor. Based on interview at the time of observation, the Maintenance Director said this area has been this way ever since he's been at the facility. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		**practice?** No residents were found to have been affected by this alleged deficient practice. The combustible materials that were in beauty shop were removed. **How will you 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 alleged deficient practice. The facility conducted an audit to ensure combustible materials are not stored in egress corridors in smoke compartments. Identified items were removed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on proper storage of combustible materials and that combustible materials must be moved if they are identified as being stored appropriately. The maintenance director/designee will complete daily rounds to identify non-compliance with storing combustible materials and correct immediately. The administrator will complete a weekly Performance Improvement tool to identify continued non-compliance. Non-compliance with daily	

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			environmental rounds and combustible material storage will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool and make further recommendations or changes as needed during the scheduled monthly meeting. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0324 SS=C Bldg. 07	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.			

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	Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect all residents, staff, and visitors in the facility.	K 0324	**E 324** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. The kitchen exhaust system in the identified Villa has been inspected and cleaned. **How will you 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 alleged deficient practice. The kitchen exhaust systems in the other 7 villas have been inspected and cleaned if indicated by the inspection. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the Standard for Ventilation Control and Fire Protection of Commercial Cooking	06/19/2023

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	Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the only inspection documentation available during the past twelve months for the range hood exhaust system was dated 04/20/23. There was no range hood exhaust system inspection report available within six months prior to the 04/20/23 date. Based on interview at the time of record review, the Maintenance Director said he could not find a range hood exhaust system inspection within six months prior to the 04/20/23 date. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		Operations requirements as related to required inspections and cleaning of the ventilation system. The inspection will be scheduled by the maintenance director/designee for monthly and annual inspections/cleaning. The administrator/designee will complete a Performance Improvement Tool monthly to ensure the inspections were completed and the findings were addressed as needed. Non-compliance with required testing inspections and cleanings will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to kitchen ventilation inspections for compliance and to make further recommendations as needed. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0345 SS=F Bldg. 07	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained			

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	in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. Based on record review and interview, the facility failed to ensure the annual testing of all devices connected to 1 of 1 fire alarm system was performed. NFPA 72, National Fire Alarm Code, the 2010 Edition, at 14.6.2.4 requires a record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 14.6.2.4: (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency (ies) (7) Designation of the detector(s) tested (8) Functional test of detectors (9)*Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Functional test of mass notification system control units (13) Functional test of signal transmission to mass notification systems (14) Functional test of ability of mass notification system to silence fire alarm notification appliances (15) Tests of intelligibility of mass notification	K 0345	**K 345** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. The components of the identified Fire Alarm System have been tested, calibrated as needed, and inspected per the NFPA 70, National, Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff, and visitors have the potential to be affected by the alleged deficient practice. The facilities other Fire Alarm Systems have been tested, calibrated as needed, and inspected per the NFPA 70, National, Electric Code, and NFPA 72, National Fire Alarm and Signaling Code.	06/19/2023

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	system speakers (16) Other tests as required by the equipment manufacturer's published instructions (17) Other tests as required by the authority having jurisdiction (18) Signatures of tester and approved authority representative (19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place) This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility was able to provide a semi-annual visual fire alarm system inspection report dated 06/24/22 performed by the facility's maintenance staff, however, there was no documentation available for an annual visual inspection and functional test of all devices connected to the fire alarm system. Based on interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure documentation was available to show that all smoke detectors were sensitivity tested within the past 24 months or prior. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on testing and maintenance of a fire alarm system accordance with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code and that documentation is readily available for review. The administrator/designee will complete a Performance Improvement Tool monthly to ensure the testing, recalibration as needed, and inspections are completed per regulations. Non-compliance with required testing, calibration, and inspection will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to Fire Alarm Systems for compliance and for further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	

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	sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility was unable to produce a			

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	smoke detector sensitivity report for all smoke detectors for the past 24 month period. Based on interview at the time of record review, the Maintenance Director confirmed there was no smoke detector sensitivity testing documentation available for the past 24 months. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)			
K 0353 SS=F Bldg. 07	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 dry sprinkler system during 41 of the past 52 weeks. NFPA 25, Standard for the Inspection, Testing, and Maintenance of	K 0353	**E 353** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	06/19/2023

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	Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: a. Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available to show the facility's dry sprinkler system gauges were inspected weekly during 41 of the past 52 week period. Based on interview at the time of record review, the Maintenance Director confirmed there was no documentation available to show that the facility's sprinkler gauges have been inspected at least weekly during 41 of the past 52 weeks. Based on observations with the Maintenance Director during a tour of the facility on 05/11/23 between 10:00 a.m. and 12:00 p.m. the facility had three pressure gauges at the sprinkler riser. b. Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no monthly sprinkler system control valves inspection documentation for 8 of the past 12 months. Based on interview at		The identified facility's dry sprinkler system gauges and control valve were inspected, and maintenance performed as indicated. The documentation is readily available. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff, and visitors have the potential to be affected by the alleged deficient practice. An audit was completed on the remainder Villas to identify sprinkler system gauges and control valve were not inspected and lacking maintenance as required. The identified areas were corrected. The documentation is readily available. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the facility's dry sprinkler system gauges, control valves, required inspections, and maintenance. The administrator/designee will complete a Performance Improvement Tool after reviewing the monthly documentation of the weekly and monthly inspections and maintenance that is performed	

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	the time of record review, the Maintenance Director confirmed the lack of sprinkler system inspections on the control valves during the past 12 months. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		as required. Non-compliance of the required weekly and monthly inspections and required maintenance will result in disciplinary action up to and including termination **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to sprinkler system gauges and control valve inspections, and required maintenance for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0712 SS=F Bldg. 07	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.			

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	19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 2 of 3 shifts during 2 of 4 quarters. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's fire drill reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility lacked fire drill documentation for the following shifts and quarters during the past 12 month period: a. First shift (day) of the first quarter (January, February, and March) of 2023 b. Second shift (evening) of the first quarter (January, February, and March) of 2023, and second quarter (April, May, and June) of 2022 and so far in 2023 Based on interview at the time of record review, the Maintenance Director confirmed the lack of fire drill reports during the previously mentioned shifts and quarters. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to provide complete fire drill documentation for 1 of 9 fire drills performed during the past 12 month period. This deficient practice could affect all residents in the facility. Findings include:	K 0712	**K 712** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. Fire drills have been conducted on both shifts (Days, Nights) in all 8 villas. Documentation is readily available. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff and visitors have the potential to be affected by the alleged deficient practice. Fire drills have been conducted on both shifts (Days, Nights) at expected and unexpected times under various conditions in all 8 villas. Documentation includes employee signatures that participated in each drill and transmission of the alarm that was received by monitoring company. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the requirements of conducting	06/19/2023

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	Based on review of the facility's fire drill reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the documented fire drill report performed on 03/28/23 (third shift of the first quarter) did not include the names and signatures of staff that participated in the fire drill. Based on interview at the time of record review, the Maintenance Director confirmed the lack of staff signatures on the fire drill report dated 03/28/23. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 3 of 9 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, fire drill reports dated 08/27/22, 10/27/22 and 03/28/23 were not provided with documentation for the transmission of the alarm to the monitoring company. Based on interview at the time of record review, the Maintenance Director acknowledged there was no information on the previously mentioned fire drill		monthly fire drills in all 8 Villas on both day shift and night shift at expected and unexpected times under various conditions and the required documentation of those that participated in the drills and transmission of the alarm that was received by the monitoring company. The administrator/designee will complete a Performance Improvement Tool to ensure the monthly fire drills were conducted at expected and unexpected times under various conditions monthly on both shifts and validate proper documentation is completed. Non-compliance with required fire drills and documentation will result in disciplinary action up to and including termination **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to the competition and proper documentation of the required fire drills for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	

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	reports to verify that transmission of the alarm was received by the monitoring company. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3-1.19(b)			
K 0914 SS=F Bldg. 07	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and interview; the facility failed to ensure complete documentation was available for all	K 0914	**K 914** **What corrective action(s) will be accomplished for those**	06/19/2023

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	nonhospital-grade electrical receptacles in all resident room locations 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 record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available of an annual resident room receptacle test for non hospital-grade receptacles. Based on interview at the time of record review, the Maintenance Director said all of the electrical receptacles in resident rooms were not hospital-grade receptacles as far as he knew. He further said he has been the Maintenance Director at the facility for only four months and could not find documentation to show that annual testing per NFPA 99, Receptacle Testing requirements was met with all pertinent information within the past 12 month period or prior. Based on observations on 05/11/23 between 10:00 a.m. and 12:00 p.m. during a tour of the facility with the Maintenance		**residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. Non-hospital grade receptacles in resident rooms have been tested for polarity, continuity of ground circuit, and retention force of grounding blade. Receptacles were replaced as indicated by the tests. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff and visitors have the potential to be affected by the alleged deficient practice. Non-hospital grade receptacles in resident rooms have been tested for polarity, continuity of ground circuit, and retention force of grounding blade. Receptacles were replaced as indicated by the tests. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director was educated on documenting the annual testing of non-hospital grade receptacles in resident rooms, to include testing for	

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	Director, there were at least four electrical receptacles in each resident room. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		polarity, continuity of ground circuit, and retention force of the grounding blade. Receptacles were replaced as indicated by the tests. The administrator/designee will complete a Performance Improvement Tool to ensure non-hospital grade receptacles are tested annually, replace when indicated by testing, and required documentation. Non-compliance with required annual test will result in disciplinary action up to and including termination **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to testing non-hospital grade receptacles annually for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0918 SS=F Bldg. 07	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			

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	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, 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 ensure a written record of weekly inspections for 1 of 1 generator was maintained for 31 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage	K 0918	**K 918** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged	06/19/2023

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	batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available to show the emergency generator was inspected/tested weekly during 31 of the most recent 52 week period (nothing since 10/03/22). Based on interview at the time of record review, the Maintenance Director said he does test/inspect of the emergency generator weekly but does not always document the test/inspection results. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 6 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency		deficient practice. The facilities five generators have the require weekly inspections/tested, monthly load toad test, annual maintenance, and 4-hour load test completed and documented according to meet NFPA emergency power and standby system requirements. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff, and visitors have the potential to be affected by the alleged deficient practice. The facilities five generators have the require weekly inspections/tested, monthly load toad test, annual maintenance, and 4-hour load test completed and documented according to meet NFPA emergency power and standby system requirements. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the NFPA's LTC emergency and standby power system requirements. The administrator/designee will complete the Performance Improvement Tool for 6 months after reviewing the weekly inspections/testing documentation	

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	electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no monthly generator load test documentation available for 6 of the past 12 months (nothing since 09/26/22) for the emergency generator. Based on interview at the time of record review, the Maintenance Director confirmed there was no emergency generator load test documentation for 6 of the past 12 months for the emergency generator. This finding was reviewed with the Executive		weekly, the monthly load toad test documentation during the scheduled monthly Quality Assurance meeting and the annual maintenance and 4-hour load test documentation during each Decembers scheduled QA meeting to ensure the requirements are met. This practice will be ongoing. Non-compliance of weekly inspections/testing documentation weekly, the monthly load toad test documentation will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related emergency and standby power system requirements for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	

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	Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 3. Based on record review and interview, the facility failed to ensure a written record of routine maintenance and testing for 1 of 1 emergency generator was maintained and available. NFPA 110, the Standard for Emergency and Standby Powers Systems, at 8.3.3 requires a written schedule for routine maintenance and operational testing of the EPSS shall be established. 8.3.4 requires a permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. 8.3.4.1 requires the permanent record shall include the following: (1) The date of the maintenance report (2) Identification of the servicing personnel (3) Notification of any unsatisfactory condition and the corrective action taken, including parts replaced (4) Testing of any repair for the time as recommended by the manufacturer. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available to show that the emergency generator has had routine maintenance during the past 12 months. Based on interview at the time of record review, the Maintenance Director said he has been the Maintenance Director at the facility for only four months and has not seen evidence/documentation that routine maintenance has been performed on the generator either in house or from an outside vendor.			

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This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23.

3.1-19(b)

4. Based on record review and interview, the facility failed to provide complete documentation for the testing of 5 of 5 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. NFPA 110, Section 8.4.9.5.3 states for spark-ignited (LP or Natural Gas) EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff, and visitors.

Findings include:

Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility could not provide documentation of a four hour load test of the LP gas fueled emergency generator within the past 36 months for the five emergency generators. This was confirmed by the Maintenance Director at the time of record review.

This finding was reviewed with the Executive Director and Maintenance Director during the exit

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	conference on 05/11/23. 3.1-19(b)			
K 0923 SS=F Bldg. 07	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated			

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	from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 2 smoke compartments. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.3 states storage for nonflammable gases with a total volume equal to or less than greater than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1 and 11.3.3.2. NFPA 99, Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations on 05/11/23 between 10:00 a.m. and 12:00 p.m. during a tour of the facility with the Maintenance Director, there was one medium sized oxygen cylinder freestanding on the floor in the back hall. The oxygen cylinder was not supported in a proper cylinder stand or otherwise secured from falling. Based on interview at the time of the observation, the Maintenance Director acknowledged the oxygen cylinder freestanding on the floor in the back hall and not supported in a cylinder stand or otherwise secured from falling. This finding was reviewed with the Executive	K 0923	**K 923** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. Oxygen cylinders have been placed in proper carts and secured with the thumb screw. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff and visitors have the potential to be affected by the alleged deficient practice. An audit was conducted to identify oxygen cylinders that were not properly secured. The identified unsecured cylinders were secured immediately. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	06/19/2023

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	Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		The Maintenance Director has been educated on securing oxygen cylinders in the proper cylinder stand and will complete environmental rounds in all 8 Villas 5 days a week for 4 weeks and then weekly x 5 months to ensure oxygen cylinders are being safely secured. The administrator will complete a Performance Improvement Tool after reviewing the environmental round sheets weekly for 6 months to ensure compliance. Non-compliance with daily environmental rounds will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance improvement Tool for compliance and to make further recommendations. By what date will the systemic changes for each deficiency be completed? 6/19/2023	
K 0000 Bldg. 08	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).	K 0000	**Plan of Correction for the Villas of Guerin Woods 2023 Life Safety Code with Emergency Preparedness Survey.**	

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	Survey Dates: 05/10/23 and 05/11/23 Facility Number: 011509 Provider Number: 155770 AIM Number: 200909280 At this Life Safety Code survey, Villas of Guerin Woods, 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), and 410 IAC 16.2. Villa 1008 was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 8 and had a census of 8 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 05/17/23		**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation**. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of the Post Survey Revisit.	
K 0291 SS=F Bldg. 08	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review, observation, and interview; the facility failed to ensure there was	K 0291	**K 291** **What corrective action(s) will**	06/19/2023

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	documentation for the testing of 5 of 5 battery backup lights that were tested monthly for 30 seconds during 6 of the past 12 months, and annually for 90 minutes during the past 12 months to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility did have a preventative maintenance (PM) report that battery powered emergency lights were tested monthly, however, there was no 30 second monthly testing documentation since 09/26/22. Furthermore, there was no documentation available to show the five battery powered emergency lights were tested annually for 90 minutes. Based on an interview at the time of record review, the Maintenance Director agreed the PM form for the battery powered emergency lights did not include 30 second monthly testing for each battery powered light since 09/26/22. Furthermore, he said there was no documentation available for an annual 90 minute test during the past 12 month period.		**be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. All 5 of the facilities battery backup lights that were tested for 90 minutes and documented accordingly. **How will you 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 alleged deficient practice. All 5 of the facilities' battery backup lights were tested for 90 minutes and documented accordingly. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the NFPA's emergency battery backup lighting's testing requirements. The 5 battery backup lights will be tested monthly by the maintenance director/designee for 30 seconds and 90 minutes annually with completed documentation. The administrator/designee will complete a Performance	

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	During a tour of the facility with the Maintenance Director on 05/11/23 between 10:00 a.m. and 12:00 p.m., the facility was equipped with five emergency battery powered lights. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		Improvement Tool monthly for 6 months after reviewing the monthly testing report to ensure the light will provide lighting during a power outage. Non-compliance with emergency battery backup lighting testing will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review Performance Improvement Tool related to emergency battery backup lighting's monthly testing for compliance and further recommendations during the scheduled monthly meeting. . **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0321 SS=F Bldg. 08	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			

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	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) 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 1 egress corridor in 1 of 2 smoke compartments was not used to store combustible material. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations on 05/11/23 between 10:00 a.m. and 12:00 p.m. during a tour of the facility with the Maintenance Director, the Beauty Shop area of the back hall was being used to store several plastic drawer type totes full of items, cardboard boxes, old furniture, and mattresses, and a variety of other storage items. This area	K 0321	**K 321** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. The combustible materials that were in beauty shop were removed. **How will you identify other residents having the potential to be affected by the same**	06/19/2023

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	was open to the egress corridor. Based on interview at the time of observation, the Maintenance Director said this area has been this way ever since he's been at the facility. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		**deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. The facility conducted an audit to ensure combustible materials are not stored in egress corridors in smoke compartments. Identified items were removed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on proper storage of combustible materials and that combustible materials must be moved if they are identified as being stored appropriately. The maintenance director/designee will complete daily rounds to identify non-compliance with storing combustible materials and correct immediately. The administrator will complete a weekly Performance Improvement tool to identify continued non-compliance. Non-compliance with daily environmental rounds and combustible material storage will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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			The Quality Assurance Committee will review the Performance Improvement Tool and make further recommendations or changes as needed during the scheduled monthly meeting. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0324 SS=C Bldg. 08	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire	K 0324	**E 324** **What corrective action(s) will be accomplished for those residents found to have been**	06/19/2023

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	Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the only inspection documentation available during the past twelve months for the range hood exhaust system was dated 04/20/23. There was no range hood exhaust system inspection report available within six months prior to the 04/20/23 date. Based on interview at the		**affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. The kitchen exhaust system in the identified Villa has been inspected and cleaned. **How will you 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 alleged deficient practice. The kitchen exhaust systems in the other 7 villas have been inspected and cleaned if indicated by the inspection. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations requirements as related to required inspections and cleaning of the ventilation system. The inspection will be scheduled by the maintenance director/designee for monthly and annual inspections/cleaning. The administrator/designee will complete a Performance Improvement Tool monthly to	

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	time of record review, the Maintenance Director said he could not find a range hood exhaust system inspection within six months prior to the 04/20/23 date. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		ensure the inspections were completed and the findings were addressed as needed. Non-compliance with required testing inspections and cleanings will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to kitchen ventilation inspections for compliance and to make further recommendations as needed. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0345 SS=F Bldg. 08	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. Based on record review and interview, the facility failed to ensure the annual testing of all devices connected to 1 of 1 fire alarm system was	K 0345	**K 345** **What corrective action(s) will be accomplished for those**	06/19/2023

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	performed. NFPA 72, National Fire Alarm Code, the 2010 Edition, at 14.6.2.4 requires a record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 14.6.2.4: (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency (ies) (7) Designation of the detector(s) tested (8) Functional test of detectors (9)*Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Functional test of mass notification system control units (13) Functional test of signal transmission to mass notification systems (14) Functional test of ability of mass notification system to silence fire alarm notification appliances (15) Tests of intelligibility of mass notification system speakers (16) Other tests as required by the equipment manufacturer's published instructions (17) Other tests as required by the authority having jurisdiction (18) Signatures of tester and approved authority representative (19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device		**residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. The components of the identified Fire Alarm System have been tested, calibrated as needed, and inspected per the NFPA 70, National, Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff, and visitors have the potential to be affected by the alleged deficient practice. The facilities other Fire Alarm Systems have been tested, calibrated as needed, and inspected per the NFPA 70, National, Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on testing and maintenance of a fire alarm system accordance with the requirements of NFPA 70,	

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	abandoned in place) This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility was able to provide a semi-annual visual fire alarm system inspection report dated 06/24/22 performed by the facility's maintenance staff, however, there was no documentation available for an annual visual inspection and functional test of all devices connected to the fire alarm system. Based on interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure documentation was available to show that all smoke detectors were sensitivity tested within the past 24 months or prior. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In		National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code and that documentation is readily available for review. The administrator/designee will complete a Performance Improvement Tool monthly to ensure the testing, recalibration as needed, and inspections are completed per regulations. Non-compliance with required testing, calibration, and inspection will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to Fire Alarm Systems for compliance and for further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	

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	zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility was unable to produce a smoke detector sensitivity report for all smoke detectors for the past 24 month period. Based on interview at the time of record review, the Maintenance Director confirmed there was no smoke detector sensitivity testing documentation available for the past 24 months. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23.			

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K 0353 SS=F Bldg. 08	3.1-19(b) NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 dry sprinkler system during 41 of the past 52 weeks. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1	K 0353	**E 353** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The identified facility's dry sprinkler system gauges and control valve were inspected, and maintenance performed as indicated. The documentation is readily available. **How will you identify other residents having the potential to be affected by the same**	06/19/2023

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	states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: a. Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available to show the facility's dry sprinkler system gauges were inspected weekly during 41 of the past 52 week period. Based on interview at the time of record review, the Maintenance Director confirmed there was no documentation available to show that the facility's sprinkler gauges have been inspected at least weekly during 41 of the past 52 weeks. Based on observations with the Maintenance Director during a tour of the facility on 05/11/23 between 10:00 a.m. and 12:00 p.m. the facility had three pressure gauges at the sprinkler riser. b. Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no monthly sprinkler system control valves inspection documentation for 8 of the past 12 months. Based on interview at the time of record review, the Maintenance Director confirmed the lack of sprinkler system inspections on the control valves during the past 12 months. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		**deficient practice and what corrective action will be taken?** All residents, staff, and visitors have the potential to be affected by the alleged deficient practice. An audit was completed on the remainder Villas to identify sprinkler system gauges and control valve were not inspected and lacking maintenance as required. The identified areas were corrected. The documentation is readily available. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the facility's dry sprinkler system gauges, control valves, required inspections, and maintenance. The administrator/designee will complete a Performance Improvement Tool after reviewing the monthly documentation of the weekly and monthly inspections and maintenance that is performed as required. Non-compliance of the required weekly and monthly inspections and required maintenance will result in disciplinary action up to and including termination **How the corrective action (s) will be monitored to ensure the deficient practice will not**	

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			recur, i.e., what quality assurance program will be put into place? The Quality Assurance Committee will review the Performance Improvement Tool related to sprinkler system gauges and control valve inspections, and required maintenance for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0712 SS=F Bldg. 08	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 provide quarterly fire drill documentation for 3 of 3 shifts during 2 of 4 quarters. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include:	K 0712	**K 712** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. Fire drills have	06/19/2023

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	Based on review of the facility's fire drill reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility lacked fire drill documentation for the following shifts and quarters during the past 12 month period: a. Second shift (evening) of the first quarter (January, February, and March) of 2023, and second quarter (April, May, and June) of 2022 and so far in 2023 b. Third shift (night) of the first quarter (January, February, and March) of 2023 Based on interview at the time of record review, the Maintenance Director confirmed the lack of fire drill reports during the previously mentioned shifts and quarters. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to provide complete fire drill documentation for 1 of 9 fire drills performed during the past 12 month period. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the documented fire drill report performed on 03/28/23 (first shift of the first quarter) did not include the names and signatures of staff that participated in the fire drill. Based on interview at the time of record review, the Maintenance Director confirmed the lack of staff signatures on the fire		been conducted on both shifts (Days, Nights) in all 8 villas. Documentation is readily available. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff and visitors have the potential to be affected by the alleged deficient practice. Fire drills have been conducted on both shifts (Days, Nights) at expected and unexpected times under various conditions in all 8 villas. Documentation includes employee signatures that participated in each drill and transmission of the alarm that was received by monitoring company. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the requirements of conducting monthly fire drills in all 8 Villas on both day shift and night shift at expected and unexpected times under various conditions and the required documentation of those that participated in the drills and transmission of the alarm that was received by the monitoring company. The administrator/designee will	

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	drill report dated 03/28/23. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 3 of 9 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, fire drill reports dated 08/27/22, 10/27/22 and 03/28/23 were not provided with documentation for the transmission of the alarm to the monitoring company. Based on interview at the time of record review, the Maintenance Director acknowledged there was no information on the previously mentioned fire drill reports to verify that transmission of the alarm was received by the monitoring company. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3-1.19(b)		complete a Performance Improvement Tool to ensure the monthly fire drills were conducted at expected and unexpected times under various conditions monthly on both shifts and validate proper documentation is completed. Non-compliance with required fire drills and documentation will result in disciplinary action up to and including termination **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to the competition and proper documentation of the required fire drills for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	

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K 0914 SS=F Bldg. 08	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and interview; the facility failed to ensure complete documentation was available for all nonhospital-grade electrical receptacles in all resident room locations 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	K 0914	**K 914** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. Non-hospital grade receptacles in resident rooms have been tested for polarity, continuity of ground	06/19/2023

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	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 record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available of an annual resident room receptacle test for non hospital-grade receptacles. Based on interview at the time of record review, the Maintenance Director said all of the electrical receptacles in resident rooms were not hospital-grade receptacles as far as he knew. He further said he has been the Maintenance Director at the facility for only four months and could not find documentation to show that annual testing per NFPA 99, Receptacle Testing requirements was met with all pertinent information within the past 12 month period or prior. Based on observations on 05/11/23 between 10:00 a.m. and 12:00 p.m. during a tour of the facility with the Maintenance Director, there were at least four electrical receptacles in each resident room. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)		circuit, and retention force of grounding blade. Receptacles were replaced as indicated by the tests. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff and visitors have the potential to be affected by the alleged deficient practice. Non-hospital grade receptacles in resident rooms have been tested for polarity, continuity of ground circuit, and retention force of grounding blade. Receptacles were replaced as indicated by the tests. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director was educated on documenting the annual testing of non-hospital grade receptacles in resident rooms, to include testing for polarity, continuity of ground circuit, and retention force of the grounding blade. Receptacles were replaced as indicated by the tests. The administrator/designee will complete a Performance Improvement Tool to ensure non-hospital grade receptacles are tested annually, replace when	

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			indicated by testing, and required documentation. Non-compliance with required annual test will result in disciplinary action up to and including termination **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related to testing non-hospital grade receptacles annually for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	
K 0918 SS=F Bldg. 08	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,			

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	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, 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 ensure a written record of weekly inspections for 1 of 1 generator was maintained for 31 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly	K 0918	**K 918** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by this alleged deficient practice. The facilities five generators have the require weekly inspections/tested, monthly load toad test, annual maintenance, and 4-hour load test completed and documented according to meet NFPA emergency power and standby system requirements.	06/19/2023

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	maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection reports on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available to show the emergency generator was inspected/tested weekly during 31 of the most recent 52 week period (nothing since 10/03/22). Based on interview at the time of record review, the Maintenance Director said he does test/inspect of the emergency generator weekly but does not always document the test/inspection results. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 6 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff, and visitors have the potential to be affected by the alleged deficient practice. The facilities five generators have the require weekly inspections/tested, monthly load toad test, annual maintenance, and 4-hour load test completed and documented according to meet NFPA emergency power and standby system requirements. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director has been educated on the NFPA's LTC emergency and standby power system requirements. The administrator/designee will complete the Performance Improvement Tool for 6 months after reviewing the weekly inspections/testing documentation weekly, the monthly load toad test documentation during the scheduled monthly Quality Assurance meeting and the annual maintenance and 4-hour load test documentation during each Decembers scheduled QA meeting to ensure the requirements are met. This	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no monthly generator load test documentation available for 6 of the past 12 months (nothing since 09/26/22) for the emergency generator. Based on interview at the time of record review, the Maintenance Director confirmed there was no emergency generator load test documentation for 6 of the past 12 months for the emergency generator. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 3. Based on record review and interview, the facility failed to ensure a written record of routine maintenance and testing for 1 of 1 emergency generator was maintained and available. NFPA		practice will be ongoing. Non-compliance of weekly inspections/testing documentation weekly, the monthly load toad test documentation will result in disciplinary action up to and including termination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Quality Assurance Committee will review the Performance Improvement Tool related emergency and standby power system requirements for compliance and to make further recommendations. **By what date will the systemic changes for each deficiency be completed?** 6/19/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155770	A. BUILDING 08 B. WING	05/11/2023

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	110, the Standard for Emergency and Standby Powers Systems, at 8.3.3 requires a written schedule for routine maintenance and operational testing of the EPSS shall be established. 8.3.4 requires a permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. 8.3.4.1 requires the permanent record shall include the following: (1) The date of the maintenance report (2) Identification of the servicing personnel (3) Notification of any unsatisfactory condition and the corrective action taken, including parts replaced (4) Testing of any repair for the time as recommended by the manufacturer. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available to show that the emergency generator has had routine maintenance during the past 12 months. Based on interview at the time of record review, the Maintenance Director said he has been the Maintenance Director at the facility for only four months and has not seen evidence/documentation that routine maintenance has been performed on the generator either in house or from an outside vendor. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) 4. Based on record review and interview, the facility failed to provide complete documentation			

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	for the testing of 5 of 5 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. NFPA 110, Section 8.4.9.5.3 states for spark-ignited (LP or Natural Gas) EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility could not provide documentation of a four hour load test of the LP gas fueled emergency generator within the past 36 months for the five emergency generators. This was confirmed by the Maintenance Director at the time of record review. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)			