STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155607	A. BUILDING -- B. WING	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BETHEL MANOR	6015 KRATZVILLE RD EVANSVILLE, IN 47710

(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: 08/05/24 and 08/06/24 Facility Number: 000436 Provider Number: 155607 AIM Number: 100275120 At this Emergency Preparedness survey, Bethel Manor was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 75 certified beds. At the time of the survey, the census was 63. Quality Review completed on 08/09/24 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective September 4, 2024 to the survey conducted August 5, 2024 – August 6, 2024. We respectfully request a paper compliance/desk review.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(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), §485.542(e) (e) Emergency and standby power systems.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joshua Bowman	CEO & Administrator	08/22/2024

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

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	The [LTC facility CAH and REH] 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), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(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),§485.542(e)(2) 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), REHs at §485.542(g), and and			

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	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 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.			

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	(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). 1. Based on record review and interview, the facility failed to ensure a written record of routine maintenance and testing for 2 of 2 emergency generators was maintained and available. NFPA 110, the Standard for Emergency and Standby Powers Systems, at Section 8.3.3 requires a written schedule for routine maintenance and operational testing of the EPSS shall be established. Section 8.3.4 requires a permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. Section8.3.4.1 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.	E 0041	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified in the summary statement of deficiencies. Service ticket placed with generator service provider and generators have now had annual preventive maintenance, load bank testing, and fuel quality test performed. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Tool developed for maintenance staff to utilize to track required preventive maintenance. Generator testing log updated to assist in accurate data collection. In-service education was also provided to maintenance staff. ***The corrective action taken to***	09/04/2024

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	Findings include: Based on record review on 08/05/24 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director and Maintenance Assistant present, there was no documentation available to show that both emergency generators have had routine maintenance during the past 12 months. The most recent routine maintenance report for the Main Building emergency generator was dated 06/27/23, which was over a month past due, furthermore, the most recent routine maintenance report for the Cottage emergency generator was dated 05/17/23, which was over two months past due. Based on interview at the time of record review, the Maintenance Director said the generator vendor has been contacted and will be at the facility by the end of the week to perform routine maintenance service on both generators. This finding was reviewed with the CEO/Administrator, Maintenance Director, and Maintenance Assistant during the exit conference on 08/06/24. 2. Based on record review and interview, the facility failed to exercise 2 of 2 emergency generators annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating.		***monitor performance to assure compliance through quality assurance is:*** The corrective action implemented to prevent the recurrence of the deficient practice includes a semi-annual Life Safety Code and Emergency Preparedness audit by the CEO and the Director of Quality. This audit will ensure the timeliness and completeness of generator inspections, testing, and preventive maintenance. Any areas identified through this audit will be immediately corrected and results reported to the Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 08/05/24 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director and Maintenance Assistant present, the monthly load percentage for both diesel powered generators was documented less than 30% during several of the past 12 months for both generators. Based on interview at the time of record review, the Maintenance Director acknowledged the generators ran under load on a monthly basis but do not achieve 30% of the name plate rating every month. Additionally, the Maintenance Director acknowledged a load bank test for the generator has not occurred within the past 12 month period. The most recent load bank test for the Main Building generator was dated 06/27/23, which was over one month past due, furthermore, the most recent load bank test for the Cottage generator was dated 05/17/23, which was over two month past due. This finding was reviewed with the CEO/Administrator, Maintenance Director, and Maintenance Assistant during the exit conference on 08/06/24.			

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	3. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 2 of 2 diesel powered generators. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on record review on 08/05/24 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director and Maintenance Assistant present, there was no documentation of an annual fuel quality test for both diesel generators available for review during the past 12 month period. The most recent annual fuel quality test for both diesel generators was dated 05/17/23, which was over two months past due. Based on interview at the time of record review, the Maintenance Director said the generator vendor has been contacted and will be at the facility by the end of the week to take the sample of fuel for the annual diesel fuel quality test. This finding was reviewed with the CEO/Administrator, Maintenance Director, and Maintenance Assistant during the exit conference on 08/06/24.			

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	4. Based on record review and interview, the facility failed to maintain a complete and accurate written record of monthly generator load testing for 2 of 2 emergency generators during 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. Findings include: Based on review of the generator inspection and testing reports on 08/05/24 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director and Maintenance Assistant present, the following was noted:			

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	a. Main Building - monthly load testing time was 25 to 28 minutes for 7 of the past 12 months, instead of a full 30 minutes. Cottage - monthly load testing time for 05/31/24 was listed as only 5 minutes (8:00 a.m. to 8:05 a.m.), also, the 07/18/24 monthly load test did not list a completed time frame, only 2:20 p.m. to (blank). b. Main Building - Transfer time always listed between 30 seconds and one minute. Cottage - Transfer time always listed between 45 seconds and five minutes. c. Main Building and Cottage - Cool down time always listed as "Yes" under "Cool down period completed?", instead of an amount of time for the cool down. Based on interview at the time of record review, the Maintenance Director acknowledged the issues with the generator documentation and further said the generator vendor was coming to the facility by the end of the week, and he would ask them about ways to correct the monthly load testing documentation. This finding was reviewed with the CEO/Administrator, Maintenance Director, and Maintenance Assistant during the exit conference on 08/06/24.			
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: 08/05/24 and 08/06/24 Facility Number: 000436	K 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our	

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	Provider Number: 155607 AIM Number: 100275120 At this Life Safety Code survey, Bethel Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a walkout lower level was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and in all resident sleeping rooms. This facility has a capacity of 63 and had a census of 54 at the time of this survey. The total capacity of both buildings was 75 and had a census of 63 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except three detached wood sheds used for facility storage. Quality Review completed on 08/09/24		regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective September 4, 2024 to the survey conducted August 5, 2024 – August 6, 2024. We respectfully request a paper compliance/desk review.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING			

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	Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS			

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	LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure 1 of 7 delayed egress locking arrangements were maintained in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect at least 24 residents, staff, and visitors in the North Hall. Findings include:	K 0222	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified in the summary statement of deficiencies. Facility had already identified door malfunctioning and a service ticket had been placed with service provider prior to the survey, but provider was waiting for necessary parts to arrive so that repair could be made. Door was able to be unlocked by entering code that was available to staff and posted next to keypad. While awaiting part arrival, door code was same code used throughout facility by staff and was also displayed next to keypad as it would have been a safety hazard to keep door remained unlocked 24/7 until repair was completed. We believe that the measures in	09/04/2024

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	Based on observation on 08/06/24 between 10:30 a.m. and 11:45 a.m. during a tour of the facility with the Maintenance Director and Maintenance Assistant, the North Hall exit door was equipped with delayed egress. When the panic bar on the door was pushed for 15 seconds the door did not release from the magnetic hold located at the top of the door. However, the magnetic hold did release the door when the code was pushed on the keypad located next to the door. Based on interview at the time of observation, the Maintenance Director acknowledged and agreed this exit door did not release when the panic bar was pushed for 15 seconds, furthermore, the Maintenance Director said the facility was already aware the delayed egress on this door was not working properly and is waiting on a part from the vendor to correct the problem. This finding was reviewed with the CEO/Administrator, Maintenance Director, and Maintenance Assistant during the exit conference on 08/06/24. 3.1-19(b)		place would be in compliance with 18.2.2.2.5 &018.2.2.2.6 as exhibited by the following: 1 Door was able to be unlocked by reliable means to the staff at all times 2 A total (complete) smoke detection system was provided throughout the locked space 3 The building is protected throughout by an approved, supervised automatic sprinkler system 4 The locks are electrical locks that fail safely so as to release upon loss of power to the device 5 The locks release by independent activation of both the smoke detection system and/or waterflow in the automatic sprinkler system 6 Only one locking device was present on the door ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Facility systems currently in place quickly identified the malfunctioning door and outside service provider was immediately contacted. Service provider was awaiting ordered part to arrive so	

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			that repair could be made. Part arrival was outside facility control. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The corrective action implemented to prevent the recurrence of the deficient practice includes a semi-annual Life Safety Code audit by the CEO and the Director of Quality. Any areas identified through this audit will be immediately corrected and results reported to the Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	
K 0324 SS=E 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			

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	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 observation and interview, the facility failed to ensure the cook top for 1 of 1 stove/oven in the Physical Therapy area was shut off at the switch when not in use. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect at least 5 resident, staff and visitors while in the Physical Therapy area. Findings include: Based on observations on 08/06/24 between 10:30 a.m. and 11:45 a.m. during a tour of the facility with the Maintenance Director and Maintenance Assistant, there was a cooktop stove/oven in the Physical Therapy area. The stove/oven was not	K 0324	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified in the summary statement of deficiencies. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Stove is not utilized and has been deactivated by unplugging and removing cord. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The corrective action implemented to prevent the recurrence of the deficient practice includes a semi-annual Life Safety Code audit by the CEO and the Director of Quality. Any areas identified through this audit will be immediately corrected and results reported to the Quality Assessment and Assurance meeting to determine if any	09/04/2024

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	being used at the time of observation and the power to the stove/oven was on. Based on interview at the time of observation, the Maintenance Director confirmed the cooktop stove/oven was not deactivated when not in use, and further said the stove/oven in the Physical Therapy area was not equipped with a disconnect switch so Physical Therapy staff could shut the power off to the stove/oven when not in use. This finding was reviewed with the CEO/Administrator, Maintenance Director, and Maintenance Assistant during the exit conference on 08/06/24. 3.1-19(b)		additional interventions are needed.	
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 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually:	K 0345	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified in the summary statement of deficiencies. ***Other residents that have the potential to be affected have been identified by:***	09/04/2024

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	a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all occupants. Findings include: Based on record review on 08/05/24 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director and Maintenance Assistant present, there was documentation provided regarding an annual fire alarm system inspection dated 06/27/24 by the facility's fire alarm inspection vendor, however, there was no semi-annual visual inspection documentation provided six months prior to the annual inspection by either the vendor or in-house maintenance staff. The prior fire alarm system annual inspection report available for review was dated 06/20/23. Based on interview at the time of record review, the Maintenance Director said a semi-annual visual inspection of the fire alarm system's devices was not performed six months prior to the annual fire alarm inspection on 06/27/24. This finding was reviewed with the CEO/Administrator, Maintenance Director, and Maintenance Assistant during the exit conference on 08/06/24. 3.1-19(b)		All residents have the potential to be affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Tool developed for maintenance staff to utilize to track required preventive maintenance and inspections. Maintenance staff received in-service education regarding required inspections. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The corrective action implemented to prevent the recurrence of the deficient practice includes a semi-annual Life Safety Code audit by the CEO and the Director of Quality. This audit will ensure the timeliness and completeness of fire alarm system inspections. Any areas identified through this audit will be immediately corrected and results reported to the Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems			

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	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 and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters for 1 of 1 sprinkler system. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical	K 0353	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified in the summary statement of deficiencies. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Tool developed for maintenance staff to utilize to track required preventive maintenance and inspections. Maintenance staff received in-service education regarding required inspections.	09/04/2024

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	waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the quarterly sprinkler system inspection records on 08/05/24 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director and Maintenance Assistant present, there was no quarterly sprinkler system inspection report available for the fourth quarter (October, November, and December) of 2023. Based on interview at the time of record review, the Maintenance Director confirmed there was no written documentation available to show the sprinkler system had been inspected during the fourth quarter of 2023. This finding was reviewed with the CEO/Administrator, Maintenance Director, and Maintenance Assistant during the exit conference on 08/06/24. 3.1-19(b)		***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The corrective action implemented to prevent the recurrence of the deficient practice includes a semi-annual Life Safety Code audit by the CEO and the Director of Quality. This audit will ensure the timeliness and completeness of sprinkler system inspections. Any areas identified through this audit will be immediately corrected and results reported to the Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The			

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	plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide a complete and accurate facility specific written fire safety plan for the protection of all residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants	K 0711	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified in the summary statement of deficiencies. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Fire emergency procedures plan has been updated to address evacuation of the smoke compartment and identifying staff member responsible for performing back-up call to 911. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The corrective action implemented to prevent the recurrence of the deficient practice includes a semi-annual audit by the CEO and the Director of Quality. This audit will ensure that the facility's	09/04/2024

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	in the event of an emergency. Findings include: Based on a review of the facility's Fire Emergency Procedures on 08/06/24 between 9:15 a.m. and 10:30 a.m. with the CEO/Administrator present, the following was noted: a. The plan did not address evacuation of the smoke compartment. b. It was not determined in the plan who is responsible for making the back up call to 911. Based on interview at the time of record review, the CEO/Administrator acknowledged and agreed that the Fire Emergency Procedures needs to be updated to include information about evacuation of the smoke compartment and who will be responsible for the back up call to 911. This finding was reviewed with the CEO/Administrator, Maintenance Director, and Maintenance Assistant during the exit conference on 08/06/24. 3.1-19(b)		evacuation plan is reviewed and updated at least annually. Any areas identified through this audit will be immediately corrected and results reported to the Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	
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.			

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	19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to ensure 9 of 12 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 08/05/24 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director and Maintenance Assistant present, 9 of 12 fire drill reports performed during the past 12 month period 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 included with 9 of 12 fire drill reports to verify that transmission of the alarm was received by the monitoring company. This finding was reviewed with the CEO/Administrator, Maintenance Director, and Maintenance Assistant during the exit conference on 08/06/24. 3-1.19(b) 3.1-51(c) 2. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 3 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all	K 0712	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified in the summary statement of deficiencies. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Fire drill form was updated with prompt to ensure transmission is received by monitoring company. In-service education was provided to maintenance staff on the timing of fire drills. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The corrective action implemented to prevent the recurrence of the deficient practice includes a semi-annual Life Safety Code audit by the CEO and the Director of Quality. This audit will ensure that fire drills are performed and documented appropriately. Any areas identified through this audit will be immediately corrected and results reported to the Quality Assessment and Assurance	09/04/2024

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	residents in the facility. Findings include: Based on review of the facility's fire drill reports on 08/05/24 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director and Maintenance Assistant present, the following was noted: a. 3 of 4 first shift (day) fire drills were performed between 9:30 a.m. and 10:31 a.m. b. 3 of 4 second shift (evening) fire drills were performed between 2:58 p.m. and 3:51 p.m. c. 3 of 4 third shift (night) fire drills were performed between 4:02 a.m. and 4:52 a.m. Based on interview at the time of record review, the Maintenance Director acknowledged the times of the first, second, and third shift fire drills were performed and agreed the times were not varied enough. This finding was reviewed with the CEO/Administrator, Maintenance Director, and Maintenance Assistant during the exit conference on 08/06/24. 3.1-19(b) 3.1-51(c)		meeting to determine if any additional interventions are needed.	
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			

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	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 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	K 0918	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified in the summary statement of deficiencies. Service ticket placed with generator service provider and generators have now had annual preventive maintenance, load bank testing, and fuel quality test performed. ***Other residents that have the potential to be affected have***	09/04/2024

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BETHEL MANOR	6015 KRATZVILLE RD EVANSVILLE, IN 47710

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	(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 08/05/24 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director and Maintenance Assistant present, there was no documentation available to show the emergency generator has had routine maintenance during the past 12 months. The most recent routine maintenance report for the emergency generator was dated 06/27/23, which was over a month past due. Based on interview at the time of record review, the Maintenance Director said the generator vendor has been contacted and will be at the facility by the end of the week to perform routine maintenance service on the generator. This finding was reviewed with the CEO/Administrator, Maintenance Director, and Maintenance Assistant during the exit conference on 08/06/24. 3.1-19(b) 2. Based on record review and interview, the facility failed to exercise 1 of 1 emergency generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the		***been identified by:*** All residents have the potential to be affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Tool developed for maintenance staff to utilize to track required preventive maintenance. Generator testing log updated to assist in accurate data collection. In-service education was also provided to maintenance staff. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The corrective action implemented to prevent the recurrence of the deficient practice includes a semi-annual Life Safety Code and Emergency Preparedness audit by the CEO and the Director of Quality. This audit will ensure the timeliness and completeness of generator inspections, testing, and preventive maintenance. Any areas identified through this audit will be immediately corrected and results reported to the Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 08/05/24 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director and Maintenance Assistant present, the monthly load percentage for the diesel powered generator was documented less than 30% during several of the past 12 months. Based on interview at the time of record review, the Maintenance Director acknowledged the generator ran under load on a monthly basis but do not achieve 30% of the name plate rating every month. Additionally, the Maintenance Director acknowledged a load bank test for the generator has not occurred within the past 12 month period. The most recent load bank test for the generator was dated 06/27/23, which was over one month past due. This finding was reviewed with the CEO/Administrator, Maintenance Director, and			

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	Maintenance Assistant during the exit conference on 08/06/24. 3.1-19(b) 3. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 diesel powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on record review on 08/05/24 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director and Maintenance Assistant present, there was no documentation of an annual fuel quality test for the diesel powered generator available for review during the past 12 month period. The most recent annual fuel quality test for the diesel powered generator was dated 05/17/23, which was over two months past due. Based on interview at the time of record review, the Maintenance Director said the generator vendor has been contacted and will be at the facility by the end of the week to take the sample of fuel for the annual diesel fuel quality test. This finding was reviewed with the			

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	CEO/Administrator, Maintenance Director, and Maintenance Assistant during the exit conference on 08/06/24. 3.1-19(b) 4. Based on record review and interview, the facility failed to maintain a complete and accurate written record of monthly generator load testing for 1 of 1 emergency generator during 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. Findings include:			

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	Based on review of the generator inspection and testing reports on 08/05/24 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director and Maintenance Assistant present, the following was noted: a. Monthly load testing time was 25 to 28 minutes for 7 of the past 12 months, instead of a full 30 minutes. b. Transfer time always listed between 30 seconds and one minute. c. Cool down time always listed as "Yes" under "Cool down period completed?", instead of an amount of time for the cool down. Based on interview at the time of record review, the Maintenance Director acknowledged the issues with the generator documentation and further said the generator vendor was coming to the facility by the end of the week and he would ask them about ways to correct the monthly load testing documentation. This finding was reviewed with the CEO/Administrator, Maintenance Director, and Maintenance Assistant during the exit conference on 08/06/24. 3.1-19(b)			
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Dates: 08/05/24 and 08/06/24	K 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these	

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	Facility Number: 000436 Provider Number: 155607 AIM Number: 100275120 At this Life Safety Code survey, the Cottage at Bethel Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 12 certified beds and had a census of 9 at the time of this survey. The total capacity of both buildings was 75 and had a census of 63 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 08/09/24		responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective September 4, 2024 to the survey conducted August 5, 2024 – August 6, 2024. We respectfully request a paper compliance/desk review.	
K 0211 SS=E Bldg. 02	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.			

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	18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 3 exit means of egress corridors were continuously maintained free of obstructions. This deficient practice could affect up to 6 residents, as well as staff and visitors. Findings include: Based on observations on 08/06/24 between 11:45 a.m. and 12:30 p.m. during a tour of the facility with the Maintenance Director and Maintenance Assistant, there was a wheelchair scale in the egress corridor outside the Laundry Room. The wheelchair scale was not in use at the time of observation. Based on interview at the time of observation, the Maintenance Director acknowledged the wheelchair scale being stored in the egress corridor and not in use at the time of observation. This finding was reviewed with the CEO/Administrator, Maintenance Director, and Maintenance Assistant during the exit conference on 08/06/24. 3.1-19(b)	K 0211	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified in the summary statement of deficiencies. ***Other residents that have the potential to be affected have been identified by:*** All residents and staff located in the east smoke compartment have the potential to be affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Scale was moved to newly identified location for usage and storage. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The corrective action implemented to prevent the recurrence of the deficient practice includes a semi-annual Life Safety Code audit by the CEO and the Director of Quality. Any areas identified through this audit will be immediately corrected and results reported to the Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	09/04/2024

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K 0345 SS=F Bldg. 02	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 18.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all occupants. Findings include: Based on record review on 08/05/24 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director and Maintenance Assistant present, there was documentation provided regarding an annual fire alarm system inspection dated 06/27/24 by the facility's fire alarm inspection vendor, however,	K 0345	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified in the summary statement of deficiencies. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Tool developed for maintenance staff to utilize to track required preventive maintenance and inspections. Maintenance staff received in-service education regarding required inspections. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:***	09/04/2024

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	there was no semi-annual visual inspection documentation provided six months prior to the annual inspection by either the vendor or in-house maintenance staff. The prior fire alarm system annual inspection report available for review was dated 06/20/23. Based on interview at the time of record review, the Maintenance Director said a semi-annual visual inspection of the fire alarm system's devices was not performed six months prior to the annual fire alarm inspection on 06/27/24. This finding was reviewed with the CEO/Administrator, Maintenance Director, and Maintenance Assistant during the exit conference on 08/06/24. 3.1-19(b)		The corrective action implemented to prevent the recurrence of the deficient practice includes a semi-annual Life Safety Code audit by the CEO and the Director of Quality. This audit will ensure the timeliness and completeness of fire alarm system inspections. Any areas identified through this audit will be immediately corrected and results reported to the Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	
K 0353 SS=F Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			

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	Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters for 1 of 1 sprinkler system. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the quarterly sprinkler system inspection records on 08/05/24 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director and Maintenance Assistant present, there was no quarterly sprinkler system inspection report available for the fourth quarter (October, November, and December) of 2023. Based on	K 0353	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified in the summary statement of deficiencies. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Tool developed for maintenance staff to utilize to track required preventive maintenance and inspections. Maintenance staff received in-service education regarding required inspections. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The corrective action implemented to prevent the recurrence of the deficient practice includes a semi-annual Life Safety Code audit by the CEO and the Director of Quality. This audit will ensure the timeliness and completeness of sprinkler system inspections. Any areas identified through this audit will be immediately corrected and results reported to the Quality Assessment and Assurance meeting to determine if any	09/04/2024

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	interview at the time of record review, the Maintenance Director confirmed there was no written documentation available to show the sprinkler system had been inspected during the fourth quarter of 2023. This finding was reviewed with the CEO/Administrator, Maintenance Director, and Maintenance Assistant during the exit conference on 08/06/24. 3.1-19(b)		additional interventions are needed.	
K 0711 SS=F Bldg. 02	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide a complete and accurate facility specific written fire safety plan for the protection of all residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 18.7.2.2. LSC 18.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms	K 0711	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified in the summary statement of deficiencies. ***Other residents that have the potential to be affected have been identified by:***	09/04/2024

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	(2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 18.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the facility's Fire Emergency Procedures on 08/06/24 between 9:15 a.m. and 10:30 a.m. with the CEO/Administrator present, the following was noted: a. The plan did not address evacuation of the smoke compartment. b. It was not determined in the plan who is responsible for making the back up call to 911. Based on interview at the time of record review, the CEO/Administrator acknowledged and agreed that the Fire Emergency Procedures needs to be updated to include information about evacuation of the smoke compartment and who will be		All residents have the potential to be affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Fire emergency procedures plan has been updated to address evacuation of the smoke compartment and identifying staff member responsible for performing back-up call to 911. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The corrective action implemented to prevent the recurrence of the deficient practice includes a semi-annual audit by the CEO and the Director of Quality. This audit will ensure that the facility's evacuation plan is reviewed and updated at least annually. Any areas identified through this audit will be immediately corrected and results reported to the Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	responsible for the back up call to 911. This finding was reviewed with the CEO/Administrator, Maintenance Director, and Maintenance Assistant during the exit conference on 08/06/24. 3.1-19(b)			
K 0712 SS=F Bldg. 02	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7 1. Based on record review and interview, the facility failed to ensure 9 of 12 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 18.7.1.4 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 08/05/24 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director and Maintenance	K 0712	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified in the summary statement of deficiencies. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur***	09/04/2024

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	Assistant present, 9 of 12 fire drill reports performed during the past 12 month period 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 included with 9 of 12 fire drill reports to verify that transmission of the alarm was received by the monitoring company. This finding was reviewed with the CEO/Administrator, Maintenance Director, and Maintenance Assistant during the exit conference on 08/06/24. 3-1.19(b) 3.1-51(c) 2. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 3 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 08/05/24 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director and Maintenance Assistant present, the following was noted: a. 3 of 4 first shift (day) fire drills were performed between 10:13 a.m. and 10:47 a.m. b. 3 of 4 second shift (evening) fire drills were performed between 3:16 p.m. and 4:00 p.m. c. 3 of 4 third shift (night) fire drills were performed between 4:12 a.m. and 5:08 a.m. Based on interview at the time of record review, the Maintenance Director acknowledged the times of the first, second, and third shift fire drills were		***include:*** Fire drill form was updated with prompt to ensure transmission is received by monitoring company. In-service education was provided to maintenance staff on the timing of fire drills. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The corrective action implemented to prevent the recurrence of the deficient practice includes a semi-annual Life Safety Code audit by the CEO and the Director of Quality. This audit will ensure that fire drills are performed and documented appropriately. Any areas identified through this audit will be immediately corrected and results reported to the Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	performed and agreed the times were not varied enough. This finding was reviewed with the CEO/Administrator, Maintenance Director, and Maintenance Assistant during the exit conference on 08/06/24. 3.1-19(b) 3.1-51(c)			
K 0918 SS=F Bldg. 02	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records			

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	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 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 08/05/24 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director and Maintenance Assistant present, there was no documentation available to show the emergency generator has had routine maintenance during the past 12 months. The most recent routine	K 0918	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified in the summary statement of deficiencies. Service ticket placed with generator service provider and generators have now had annual preventive maintenance, load bank testing, and fuel quality test performed. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Tool developed for maintenance staff to utilize to track required preventive maintenance. Generator testing log updated to assist in accurate data collection. In-service education was also provided to maintenance staff. ***The corrective action taken to monitor performance to assure***	09/04/2024

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	maintenance report for the emergency generator was dated 05/17/23, which was over two months past due. Based on interview at the time of record review, the Maintenance Director said the generator vendor has been contacted and will be at the facility by the end of the week to perform routine maintenance service on the generator. This finding was reviewed with the CEO/Administrator, Maintenance Director, and Maintenance Assistant during the exit conference on 08/06/24. 3.1-19(b) 2. Based on record review and interview, the facility failed to exercise 1 of 1 emergency generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous		***compliance through quality assurance is:*** The corrective action implemented to prevent the recurrence of the deficient practice includes a semi-annual Life Safety Code and Emergency Preparedness audit by the CEO and the Director of Quality. This audit will ensure the timeliness and completeness of generator inspections, testing, and preventive maintenance. Any areas identified through this audit will be immediately corrected and results reported to the Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	hours. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 08/05/24 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director and Maintenance Assistant present, the monthly load percentage for the diesel powered generator was documented less than 30% during several of the past 12 months. Based on interview at the time of record review, the Maintenance Director acknowledged the generator ran under load on a monthly basis but did not achieve 30% of the name plate rating every month. Additionally, the Maintenance Director acknowledged a load bank test for the generator has not occurred within the past 12 month period. The most recent load bank test for the generator was dated 05/17/23, which was over two month past due. This finding was reviewed with the CEO/Administrator, Maintenance Director, and Maintenance Assistant during the exit conference on 08/06/24. 3.1-19(b) 3. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 diesel powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be			

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	performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on record review on 08/05/24 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director and Maintenance Assistant present, there was no documentation of an annual fuel quality test for the diesel powered generator available for review during the past 12 month period. The most recent annual fuel quality test for the diesel powered generator was dated 05/17/23, which was over two months past due. Based on interview at the time of record review, the Maintenance Director said the generator vendor has been contacted and will be at the facility by the end of the week to take the sample of fuel for the annual diesel fuel quality test. This finding was reviewed with the CEO/Administrator, Maintenance Director, and Maintenance Assistant during the exit conference on 08/06/24. 3.1-19(b) 4. Based on record review and interview, the facility failed to maintain a complete and accurate written record of monthly generator load testing for 1 of 1 emergency generator during 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			

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	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 review of the generator inspection and testing reports on 08/05/24 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director and Maintenance Assistant present, the following was noted: a. Monthly load testing time for 05/31/24 was listed as only 5 minutes (8:00 a.m. to 8:05 a.m.), also, the 07/18/24 monthly load test did not list a completed time frame, only 2:20 p.m. to (blank). b. Transfer time always listed between 45 seconds and five minutes. c. Cool down time always listed as "Yes" under "Cool down period completed?", instead of an amount of time for the cool down.			

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	Based on interview at the time of record review, the Maintenance Director acknowledged the issues with the generator documentation and further said the generator vendor was coming to the facility by the end of the week, and he would ask them about ways to correct the monthly load testing documentation. This finding was reviewed with the CEO/Administrator, Maintenance Director, and Maintenance Assistant during the exit conference on 08/06/24. 3.1-19(b)			