STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155730	A. BUILDING -- B. WING	10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIPLEY CROSSING	1200 WHITLATCH WAY MILAN, IN 47031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/26/22 Facility Number: 000420 Provider Number: 155730 AIM Number: 100266230 At this Emergency Preparedness survey, Ripley Crossing was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 100 certified beds. At the time of the survey, the census was 74. Quality Review completed on 10/31/22 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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	§485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(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 the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed,			

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	and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). In the Survey & Certification memo QSO: 19-06-ALL dated 02/01/19, the Centers for Medicare and Medicaid Services (CMS) updated Appendix Z of the State Operations Manual to reflect changes to add emerging infectious diseases to the definition of all-hazards approach and stated "Planning for using an all-hazards approach should also include emerging infectious	E 0006	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Corrective Action: The Emergency Plan was updated to include a policy that addresses emerging infectious disease threats. This was also included in the “Hazard & Security Vulnerability Assessment". Administrator and/or Maintenance will review and update policies as needed no less than every 2 years. This was completed on November 10, 2022.	11/10/2022

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	disease (EID) threats. Examples of EIDs include Influenza, Ebola, Zika Virus and others". This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness" documentation dated 12/28/21 with the Maintenance Assistant during record review from 10:15 a.m. to 11:55 a.m. on 10/26/22, a documented facility-based and community-based risk assessment addressing emerging infectious disease (EID) threats was not available for review. EID was not included in the current "Hazard and Security Vulnerability Assessment" for the facility. Based on interview at the time of record review, the Maintenance Assistant agreed emergency preparedness program documentation did not address emerging infectious diseases (EID) as part of the facility-based and community-based risk assessment as mandated by the CMS Survey & Certification memo QSO: 19-06-ALL. This finding was reviewed with the Maintenance Assistant during the exit conference.			
E 0013 SS=F 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).			

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	(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 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.			

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	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 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 review and update its emergency preparedness policies and procedures to include policies and procedures for emerging infectious diseases (EID) in accordance with the CMS Survey & Certification memo QSO: 19-06-ALL. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 416.54(b). This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Preparedness" documentation dated 12/28/21 with the Maintenance Assistant during record review from 10:15 a.m. to 11:55 a.m. on 10/26/22, emergency preparedness policies and procedures for Emerging Infectious Diseases (EID) based on a documented facility based and community based risk assessment reviewed within the most recent	E 0013	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Corrective Action: The Emergency Plan was updated to include a policy that addresses emerging infectious disease threats. This was also included in the “Hazard & Security Vulnerability Assessment. Administrator and/or Maintenance will review and update policies as needed no less than every 2 years. This was completed on November 10, 2022.	11/10/2022

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	twelve month period was not available for review. Emergency preparedness policies and procedures did not include EID. Based on interview at the time of record review, the Maintenance Assistant agreed EID policies and procedures was not available for review at the time of the survey. This finding was reviewed with the Maintenance Assistant during the exit conference.			
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, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.			

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	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 document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1			

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	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, observation and interview; the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff and visitors. Findings include:	E 0041	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Corrective Action: Load test was done on November 2, 2022. Moving forward, the Emergency Generator testing log for the monthly load test and weekly inspection will be reviewed weekly by the Administrator and Maintenance Supervisor. Previous	11/30/2022

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	a. Based on review of "Emergency Generator Testing Log" documentation for the most recent twelve month period with the Maintenance Assistant during record review from 10:15 a.m. to 11:55 a.m. on 10/26/22, monthly load testing documentation for the facility's diesel fired emergency generator for April 2022, July 2022 and August 2022 did not indicate the monthly load test was conducted for a minimum of 30 minutes. Based on interview at the time of record review, the Maintenance Assistant agreed monthly load testing documentation for the aforementioned three month period did not indicate the monthly load test was conducted for a minimum of 30 minutes. Based on observations with the Maintenance Assistant during a tour of the facility from 11:55 a.m. to 1:45 p.m. on 10/26/22, the diesel fired emergency generator for the facility located outside the building had an affixed nameplate indicating the generator was rated at 50 kW and was manufactured in 2020. b. Based on review of "Emergency Generator Testing Log" documentation for the most recent twelve month period with the Maintenance Assistant during record review from 10:15 a.m. to 11:55 a.m. on 10/26/22, weekly generator inspection documentation for 20 weeks of the 40 week period in 2022 of 01/01/22 through 10/05/22 was incomplete. Check boxes are listed on the aforementioned weekly inspection documentation to indicate if the results of the weekly inspection were "Satisfactory" or "Unsatisfactory" but neither box was checked for 20 weeks in 2022. Based on interview at the time of record review, the Maintenance Assistant agreed weekly inspection documentation for 20 weeks in 2022 was incomplete. Based on observations with the Maintenance Assistant during a tour of the facility from 11:55 a.m. to 1:45 p.m. on 10/26/22, the		Maintenance Supervisor failed to document appropriate testing among other issues and is no longer an employee. An emergency stop label was ordered and placed by the emergency stop button on November 15, 2022. A safety indicator installation for the remote emergency stop activation has been scheduled with GenSet for completion between November 18, 2022 and no later than November 30, 2022 Administrator and Maintenance will review the Emergency Generator testing weekly. To further prevent any deficiency from reoccurring the safety indicator will be permanently installed on the annunciator. The load test was completed on November 2, 2022, and the Emergency Generator Testing Log will be reviewed weekly for 8 weeks and then monthly to ensure the deficient practice will not reoccur. The safety indicator will be installed no later than November 30, 2022.	

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	diesel fired emergency generator for the facility located outside the building had an affixed nameplate indicating the generator was rated at 50 kW and was manufactured in 2020. c. Based on observations with the Maintenance Assistant during a tour of the facility from 11:55 a.m. to 1:45 p.m. on 10/26/22, the diesel fired emergency generator for the facility located outside the building had an affixed nameplate indicating the generator was rated at 50 kW and was manufactured in 2020. A remote emergency stop button was located on the exterior of the weather proof shell for the emergency generator but the remote emergency stop button was not labeled. Based on interview at the time of the observations, the Maintenance Assistant agreed the remote manual stop station was not labeled. d. Based on observations with the Maintenance Assistant during a tour of the facility from 11:55 a.m. to 1:45 p.m. on 10/26/22, the diesel fired emergency generator for the facility located outside the building had an affixed nameplate indicating the generator was rated at 50 kW and was manufactured in 2020. A remote emergency stop button was located on the exterior of the weather proof shell for the emergency generator. The remote annunciator for the emergency generator was located at the Wing 4 nurse's station but the annunciator did not have a safety indicator for remote emergency stop activation for generator shutdown. Based on interview at the time of the observations, the Maintenance Assistant stated the remote annunciator for the generator was replaced when a new emergency generator was installed within the last couple years and agreed the remote alarm annunciator panel at the Wing 4 nurse's station did not have a safety indicator for remote emergency stop			

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	activation for generator shutdown. These findings were reviewed with the Maintenance Assistant during the exit conference.			
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/26/22 Facility Number: 000420 Provider Number: 155730 AIM Number: 100266230 At this Life Safety Code survey, Ripley Crossing was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and in all resident sleeping rooms. The facility has a capacity of 100 and had a census of 74 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which	K 0000		

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	was not sprinklered. Quality Review completed on 10/31/22			
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 1. Based on record review, observation and interview; the facility failed to document monthly and annual testing for all battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) 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, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (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, staff and visitors. Findings include: Based on review of "Ripley Crossing	K 0291	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Corrective Action: The Emergency/Exit Light Testing Form was updated to include the light(s) location. For the 1 battery powered emergency lighting system not working, a new battery was put in on November 7, 2022 and is now working properly. To further prevent this deficiency from occurring the Maintenance and/or Designee with test all emergency/exit lights monthly. This was completed on November 10, 2022.	11/10/2022

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	Emergency/Exit Light Test" documentation with the Maintenance Assistant during record review from 10:15 a.m. to 11:55 a.m. on 10/26/22, monthly and annual battery operated light testing documentation for the most recent twelve month period was not itemized by light location. Based on interview at the time of record review, the Maintenance Assistant agreed monthly and annual functional testing documentation for all battery operated lights in the facility for the most recent twelve month period was not itemized by light location. Based on observations with the Maintenance Assistant during a tour of the facility from 11:55 a.m. to 1:45 p.m. on 10/26/22, over 25 battery operated lighting systems were noted in the facility and each battery operated light which could be tested functioned when its respective test button was pushed except for the battery operated light located above the delayed egress door in the "Healthy Hoosiers" Club room. This finding was reviewed with the Maintenance Assistant during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of over 25 battery powered emergency lighting systems was maintained in accordance with LSC Section 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. This deficient practice could affect over 5 residents, staff and visitors in the "Healthy Hoosiers" Club room.			

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	Findings include: Based on observations with the Maintenance Assistant during a tour of the facility from 11:55 a.m. to 1:45 p.m. on 10/26/22, over 25 battery operated lighting systems were noted in the facility and each battery operated light which could be tested functioned when its respective test button was pushed except for the battery operated light located above the delayed egress door in the "Healthy Hoosiers" Club room. Based on interview at the time of the observations, the Maintenance Assistant agreed the aforementioned battery powered emergency lighting system failed to illuminate when its respective test button was pushed multiple times. This finding was reviewed with the Maintenance Assistant during the exit conference. 3.1-19(b)			
K 0321 SS=E Bldg. 01	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			

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	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 2 of over 20 hazardous areas such as fuel-fired heater rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Assistant during a tour of the facility from 11:55 a.m. to 1:45 p.m. on 10/26/22, the following was noted: a. the entry door to the closet in the Dementia Program Coordinator office near the Chapel was not self closing or automatic closing. The closet contained one natural gas fired furnace. b. The Mechanical Room in the dining room in Wing 3 contained one natural gas fired furnace and one natural gas fired water heater. The entry to the room was two wood doors swinging in	K 0321	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Correction Action: A self-closure was installed on the closet in the Dementia Program Director to meet the requirement of a self-closing or automatic closing door on November 15, 2022. For the fire doors on the Wing 3 Mechanical Room we ordered Astragals on November 15, 2022, and they will be installed to correct to an 1/8" gap where the doors come together once they are delivered. To further prevent any deficiency from reoccurring the self-closure will be permanently installed on the closet door in the Dementia Program Director's office. Maintenance Supervisor and/or Designee will monitor fire doors to	11/15/2022

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	pairs and had a one half inch gap at the meeting edge of the doors. Based on interview at the time of the observations, the Maintenance Assistant agreed the Dementia Program Coordinator closet door was not self closing or automatic closing and the gap at the meeting edge of the Wing 3 Mechanical Room doors was one half inch which did not separate these hazardous areas from other spaces with smoke resistant partitions and doors. This finding was reviewed with the Maintenance Assistant during the exit conference. 3.1-19(b)		ensure there are no gaps where the doors come together on weekly rounds and no less than yearly with our Annual Fire Door Inspection. This will be completed by November 21, 2022.	
K 0324 SS=D 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			

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	Based on record review and interview, the facility failed to ensure repair documentation was available for review to ensure 1 of 1 kitchen range hood exhaust systems was maintained in proper working order. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition, Section 4.1.3 states the following equipment shall be kept in working condition: (1) Cooking equipment (2) Hoods (3) Ducts (if applicable) (4) Fans (5) Fire-extinguishing equipment (6) Special effluent or energy control equipment Section 4.1.3.1 states maintenance and repairs shall be performed on all components at intervals necessary to maintain good working condition. This deficient practice could affect over two kitchen staff. Findings include: Based on review of the kitchen range hood inspection contractor's "Pre-Engineered Restaurant Fire Suppression Systems Report" documentation dated 06/17/21 and 06/28/22 with the Maintenance Assistant during record review from 10:15 a.m. to 11:55 a.m. on 10/26/22, the kitchen exhaust system has deficiencies as a result of inspection. The "Comments" section of the 06/17/21 and 06/28/22 inspection reports stated "Exhaust fan does not kick on upon system activation". Based on interview at the time of record review, the Maintenance Assistant stated he was not aware if any repairs had been made on or after 06/28/22 and agreed documentation of any corrections performed on or after 06/28/22 was not available for review at the time of the survey.	K 0324	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Corrective Action: R. C. Electric will wire the kitchen hood so that the exhaust fan will turn on when the fire suppression system shuts off. Maintenance Supervisor and/or Designee will review annual inspection reports and act accordingly on any repairs needed. To prevent any further deficiency this will be permanently fixed. This will be completed within 30 days.	12/09/2022

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	This finding was reviewed with the Maintenance Assistant during the exit conference. 3.1-19(b)			
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of over 40 resident sleeping rooms in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of resident sleeping Room 509 in Wing 5.	K 0351	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Corrective Action: Maintenance replaced the escutcheon on the 1 sprinkler in room 509 that was missing. Maintenance Supervisor and/or Designee will monitor sprinklers on weekly rounds to ensure compliance.	10/27/2022

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	Findings include: Based on observations with the Maintenance Assistant during a tour of the facility from 11:55 a.m. to 1:45 p.m. on 10/26/22, one of two ceiling mounted sprinklers in resident sleeping Room 509 in Wing 5 was missing its escutcheon. Based on interview at the time of the observations, the Maintenance Assistant agreed the ceiling mounted sprinkler near the corridor door to Room 509 was missing its escutcheon. This finding was reviewed with the Maintenance Assistant during the exit conference. 3.1-19(b)		This was completed on October 27, 2022.	
K 0353 SS=F Bldg. 01	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 observation and interview, the facility	K 0353	It is the intent of Ripley Crossing	10/28/2022

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	failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Section 5.2.2.2 requires sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect all occupants. Findings include: Based on observations with the Maintenance Assistant during a tour of the facility from 11:55 a.m. to 1:45 p.m. on 10/26/22, wiring was affixed to horizontal sprinkler piping near the ceiling in the Wing 3 Mechanical Room and to horizontal natural gas piping below the sprinkler pipe to support the natural gas piping for a natural gas fired water heater in the room. Based on interview at the time of the observations, the Maintenance Assistant agreed sprinkler piping was used to support non-system components in the Wing 3 Mechanical Room. This finding was reviewed with the Maintenance Assistant during the exit conference. 3.1-19(b)		to provide a safe environment for all residents and staff. Corrective Action: Maintenance removed the support from the gas pipe to the sprinkler pipe and ran a support for the gas pipe to the ceiling. To further prevent any deficiency, we have replaced the support for the gas pipe permanently to the ceiling. Maintenance Supervisor and/or Designee will monitor pipe supports on weekly rounds. This was completed on October 28, 2022.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material			

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	capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of over 50 corridor doors would resist the passage of smoke. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the "Healthy Hoosiers"	K 0363	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Corrective Action: Maintenance repaired the hole noted above the	10/27/2022

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	Club room in Wing 5 Findings include: Based on observations with the Maintenance Assistant during a tour of the facility from 11:55 a.m. to 1:45 p.m. on 10/26/22, a one half inch in diameter hole was noted above the door handle for the corridor door to the "Healthy Hoosiers" Club room in Wing 5 which would not resist the passage of smoke. Based on interview at the time of the observations, the Maintenance Assistant agreed the corridor door to the "Healthy Hoosiers" Club room in Wing 5 would not resist the passage of smoke. This finding was reviewed with the Maintenance Assistant during the exit conference. 3.1-19(b)		door handle for the corridor door to the therapy room. Maintenance Supervisor and/or Designee will monitor fire doors to ensure no holes are in the door on weekly rounds and no less than yearly with our Annual Fire Door Inspection. This was completed on October 27, 2022.	
K 0522 SS=F Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure natural gas fired furnaces and natural gas fired water heaters in five of over twenty hazardous areas in the facility were	K 0522	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Corrective Action: Gehrings will	12/09/2022

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	provided with combustion air taken directly from the outside or was chimney or vent connected. This deficient practice could affect over 60 residents, staff and visitors. Findings include: Based on observations with the Maintenance Assistant during a tour of the facility from 11:55 a.m. to 1:45 p.m. on 10/26/22, the following was noted: a. the natural gas fired furnace in the closet in the Dementia Program Coordinator office near the Chapel had one PVC pipe serving as the make up air supply for the furnace and one PVC pipe serving as the exhaust for the furnace. One of the two PVC pipes was detached from the furnace and it could not be determined if it was for makeup air or for the furnace exhaust. b. the PVC pipe at the burner at the top of the natural gas fired water heater in the Mechanical Room containing the facility's three dry sprinkler system risers terminated just above the burner and it was not clear if the piping was intended to supply makeup air or the exhaust for the burner. No makeup air for the water heater in the room could be located. c. the natural gas fired water heaters in the Mechanical Room in the dining rooms in Wing 1, Wing 2 and Wing 3 were not provided with combustion air taken directly from the outside. Based on interview at the time of the observations, the Maintenance Assistant agreed the natural gas fired water heaters in the three wings were not provided with combustion air taken directly from the outside and the furnace and the water heater in the riser room were not chimney or vent connected. This finding was reviewed with the Maintenance		complete the installation on the Furnace/AC in the Dementia Program Directors office. Gehrings will also install appropriate venting needed to the 4 water heaters to bring up to code To further prevent deficiency the Furnace/AC will be repaired as specified and the gas fired water heaters will have correct ventilation installed permanently. This will be completed in 30 days.	

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	Assistant during the exit conference. 3.1-19(b)			
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 Based on record review and interview, the facility failed to document quarterly fire drills or staff training documentation on fire drill procedures on the second shift for 2 of 4 quarters and on the third shift for 1 of 4 quarters. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Fire Drill Report" documentation with the Maintenance Assistant during record review from 10:15 a.m. to 11:55 a.m. on 10/26/22, documentation of a second shift fire drill or staff training documentation on fire drill procedures in the second quarter (April, May, June) 2022 and the third quarter (July, August, September) 2022 was not available for review. In addition, documentation of a third shift fire drill or staff training documentation on fire drill procedures in the second quarter 2022 was also not available for review. Based on interview at the	K 0712	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Corrective Action: Maintenance conducted a 3rd shift fire drill on October 28, 2022 and a 2nd shift fire drill on November 17, 2022. Moving forward, the Maintenance department will conduct at least quarterly on each shift. Previous Maintenance Supervisor failed to document/conduct quarterly fire drills on each shift among other issues and is no longer an employee. Administrator and Maintenance will review fire drills monthly for 6 months and annually thereafter. This was completed on November 17, 2022.	11/17/2022

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	time of record review, the Maintenance Assistant stated the facility operates three shifts per day and agreed documentation of a fire drill or staff training on fire drill procedures for the aforementioned shifts and quarters was not available for review. This finding was reviewed with the Maintenance Assistant during the exit conference. 3.1-19(b)			
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 Based on observation and interview, the facility failed to ensure 4 of 6 smoke compartments was maintained in accordance with 19.7.5.6. 19.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and	K 0753	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Corrective Action: All Halloween decorations were removed from all doors. To ensure no further deficiency is cited the Activity Director will	10/27/2022

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	labeled for application to the material to which it is applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 19.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. (5)*They are decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present. This deficient practice could affect over 40		inservice activity staff regarding combustible decoration on fire-rated doors unless flame retardant. Activity Director and/or designee will monitor decorations on rounds. This was completed on October 27, 2022.	

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	residents, staff and visitors. Findings include: Based on observations with the Maintenance Assistant during the initial walk through of the facility from 9:40 a.m. to 9:55 a.m. on 10/26/22, plastic sheeting and other miscellaneous combustible Halloween decorations were hung on or affixed to corridor doors to multiple office areas and other non-resident room areas. Based on observations with the Maintenance Assistant during a tour of the facility from 11:55 a.m. to 1:45 p.m. on 10/26/22, the following was noted: a. plastic film covering most of the the corridor door and Halloween theme decorated socks were affixed to the face of the corridor door to the Medical Records office by the Chapel. b. plastic film was affixed to the entire face of the corridor door to the Mechanical Room by the entrance doors to Wing 4. c. plastic film and combustible Halloween decorations were affixed to nearly the entire face of the corridor door to resident sleeping Room 110 in Wing 1. d. plastic film and combustible Halloween decorations were affixed to the entire face of the corridor door to the Family Room in Wing 3. e. plastic film and combustible Halloween decorations were affixed to the entire face of the corridor door to the Housekeeping Office by the Laundry Room. Neither the plastic film or the Halloween decorations had affixed documentation indicating the material was fire retardant or fire retardant treated. Based on interview at the time of the observations, the Maintenance Assistant stated he was not aware if the affixed decorations had been treated with fire retardant material and agreed the fire resistance rating for the			

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	decorations was not available for review. This finding was reviewed with the Maintenance Assistant during the exit conference. 3.1-19(a)			
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility failed to ensure soiled linen and trash receptacles in 2 of over 40 resident sleeping rooms were stored in a room protected as a hazardous area in accordance with 19.7.5.7. This deficient practice could affect over 20 residents, staff and visitors in Wing 4. Findings include: Based on observations with the Maintenance	K 0754	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Corrective Action: The Soiled Linen and Trash Containers were replaced with 20-gallon containers. Director of Nursing and/or Designee will inservice nursing staff to ensure the proper sized containers will be used when necessary.	10/27/2022

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	Assistant during a tour of the facility from 11:55 a.m. to 1:45 p.m. on 10/26/22, one 20 gallon capacity soiled linen container and one 32 gallon capacity trash cart each partially filled with soiled linen or trash were stored next to one another in resident sleeping Room 405 in Wing 4. One 32 gallon capacity trash cart and one small trash can were stored next to one another in resident sleeping Room 403 in Wing 4. The corridor door to each resident sleeping room was not self closing or automatic closing. Based on interview at the time of the observations, the Maintenance Assistant agreed a total container capacity of 32 gallons of soiled linen and trash was exceeded within a 64 square feet area in the two resident sleeping rooms and the rooms were not protected as a hazardous area. This finding was reviewed with the Maintenance Assistant during the exit conference. 3.1-19(b)		This was completed on October 27, 2022.	
K 0916 SS=E Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator with all	K 0916	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff.	11/30/2022

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	required safety indicators and shutdowns. NFPA 99, 2012 Edition, Health Care Facilities Code, at 6.4.1.1.17 requires a remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate: a. When the emergency or auxiliary power source is operating to supply power to load. b. When the battery charger is malfunctioning. (2) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: a. Low lubricating oil pressure. b. Low water temperature. c. Excessive water temperature. d. Low fuel when the main fuel storage tank contains less than a 4-hour operating supply. e. Overcrank (failed to start). f. Overspeed. Individual alarm indication to annunciate any of the conditions listed in Table 6.4.1.1.16.2 shall have the following characteristics: (1) It shall be battery powered. (2) It shall be visually indicated. (3) It shall have additional contacts or circuits for a common audible alarm that signals locally and remotely when any of the itemized conditions occurs. (4) It shall have a lamp test switch(es) to test the operation of all alarm lamps. Table 6.4.1.1.16.2(v) states remote emergency stop shutdown shall be indicated. This deficient practice could affect all residents, staff and visitors.		Corrective Action: A safety indicator installation for the remote emergency stop activation has been scheduled with GenSet for completion between November 18, 2022 and no later than November 30, 2022 To further prevent any deficiency from reoccurring the safety indicator will be permanently installed on the annunciator. The safety indicator will be installed no later than November 30, 2022.	

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	Findings include: Based on observations with the Maintenance Assistant during a tour of the facility from 11:55 a.m. to 1:45 p.m. on 10/26/22, the diesel fired emergency generator for the facility located outside the building had an affixed nameplate indicating the generator was rated at 50 kW and was manufactured in 2020. A remote emergency stop button was located on the exterior of the weather proof shell for the emergency generator. The remote annunciator for the emergency generator was located at the Wing 4 nurse's station but the annunciator did not have a safety indicator for remote emergency stop activation for generator shutdown. Based on interview at the time of the observations, the Maintenance Assistant stated the remote annunciator for the generator was replaced when a new emergency generator was installed within the last couple years and agreed the remote alarm annunciator panel at the Wing 4 nurse's station did not have a safety indicator for remote emergency stop activation for generator shutdown. This finding was reviewed with the Maintenance Assistant during the exit conference. 3.1-19(b)			
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			

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	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, observation and interview; the facility failed to document emergency generator monthly load testing for 3 months of the most recent 12 month period 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	K 0918	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Corrective Action: Load test was done on November 2, 2022. Weekly generator testing inspections were completed on November 2, November 9 & November 16. Moving forward, the Emergency Generator testing log for the monthly load test and weekly testing inspection will be	11/16/2022

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	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 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 review of "Emergency Generator Testing Log" documentation for the most recent twelve month period with the Maintenance Assistant during record review from 10:15 a.m. to 11:55 a.m. on 10/26/22, monthly load testing documentation for the facility's diesel fired emergency generator for April 2022, July 2022 and August 2022 did not indicate the monthly load test was conducted for a minimum of 30 minutes. Based on interview at the time of record review, the Maintenance Assistant agreed monthly load testing documentation for the aforementioned three month period did not indicate the monthly load test was conducted for a minimum of 30 minutes. Based on observations with the Maintenance Assistant during a tour of the facility from 11:55 a.m. to 1:45 p.m. on 10/26/22, the diesel fired emergency generator for the facility located outside the building had an affixed nameplate indicating the generator was rated at 50 kW and was manufactured in 2020.		reviewed weekly by the Administrator and Maintenance Supervisor for complete documentation. Previous Maintenance Supervisor failed to document appropriate testing among other issues and is no longer an employee. Administrator and Maintenance will review the Emergency Generator testing weekly. This will be completed on November 16, 2022, and the Emergency Generator Testing Log will be reviewed weekly for 8 weeks and then monthly to ensure the deficient practice will not reoccur.	

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	This finding was reviewed with the Maintenance Assistant during the exit conference. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to ensure a written record of weekly inspections for the generator was maintained for 20 weeks of 40 weeks in 2022. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator Testing Log" documentation for the most recent twelve month period with the Maintenance Assistant during record review from 10:15 a.m. to 11:55 a.m. on 10/26/22, weekly generator inspection documentation for 20 weeks of the 40 week period in 2022 of 01/01/22 through 10/05/22 was incomplete. Check boxes are listed on the aforementioned weekly inspection documentation to indicate if the results of the weekly inspection were "Satisfactory" or "Unsatisfactory" but neither box was checked for 20 weeks in 2022. Based on interview at the time of record review, the Maintenance Assistant agreed weekly			

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	inspection documentation for 20 weeks in 2022 was incomplete. Based on observations with the Maintenance Assistant during a tour of the facility from 11:55 a.m. to 1:45 p.m. on 10/26/22, the diesel fired emergency generator for the facility located outside the building had an affixed nameplate indicating the generator was rated at 50 kW and was manufactured in 2020. This finding was reviewed with the Maintenance Assistant during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 2 remote manual stops for the facility's emergency generator was labeled in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 15.5.1.3 states emergency generators and standby power system, where required for compliance with this code, shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 2010 edition, 5.6.5.6 states all installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. The remote manual stop station shall be labeled. This deficient practice could affect all patients, staff and visitors. Findings include: Based on observations with the Maintenance Assistant during a tour of the facility from 11:55 a.m. to 1:45 p.m. on 10/26/22, the diesel fired emergency generator for the facility located			

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	outside the building had an affixed nameplate indicating the generator was rated at 50 kW and was manufactured in 2020. A remote emergency stop button was located on the exterior of the weather proof shell for the emergency generator but the remote emergency stop button was not labeled. Based on interview at the time of the observations, the Maintenance Assistant agreed the remote manual stop station was not labeled. This finding was reviewed with the Maintenance Assistant during the exit conference. 3.1-19(b)			