STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155718	A. BUILDING -- B. WING	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHVIEW HEALTH AND LIVING	1235 W CROSS ST ANDERSON, IN 46011

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/09/24 Facility Number: 000562 Provider Number: 155718 AIM Number: 100267150 At this Emergency Preparedness survey, Northview Health and Living was found not compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 101 certified beds. At the time of the survey, the census was 69. Quality Review completed on 04/15/24	E 0000	This Plan Of Correction constitutes the written allegation of compliance for deficiencies cited. The submission of this Plan of Correction is not an admission that a deficiency exists or that it was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law.	
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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kim Carlson	HFA	05/01/2024

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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	systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain			

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	the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013.			

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	(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director (MD), Administrator and Maintenance Facility Support staff on 04/09/24 between 10:00 a.m. and 12:15 p.m., no documentation of an annual fuel quality test for the diesel generator was available for review. The facility has 1 Diesel fired generator. Based on interview at the time of records review, the fuel quality testing for the diesel fired generator could not be located. The MD reached out to the company that services the generator, but no documentation was available for review. This finding was acknowledged by the MD at the time of discovery and again by the Maintenance Director (MD), Administrator and Maintenance Facility Support person at the exit.	E 0041	**E041** **What Corrective Action will be accomplished for those residents found to have been affected by this deficient Practice:** No residents were affected by this deficient practice. Further investigation by the Maintenance Director located documentation of annual fuel quality test. Attachment #1 shows test was completed on 7/27/2023. **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken:** No residents have the potential to be affected by this same practice due to testing done in timely manner, shown in attachment #1. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur.** Dates have been entered into the Maintenance Director TELS system to receive alerts when testing will be done. Documentation that annual test has been completed will be copied and placed in binder of required documentation in Maintenance Director office.	05/09/2024

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			How will the corrective action be monitored to ensure the deficient practice will not recur: The Maintenance Director will copy Administrator on receipt of annual fuel quality test results upon receipt. Next annual fuel quality test is scheduled and tagged in TELS system. Will be reviewed at QAPI meeting to ensure compliance and continue for at least 6 months review.	
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: 04/09/24 Facility Number: 000562 Provider Number: 155718 AIM Number: 100267150 At this Life Safety Code survey, Northview Health and Living 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 (000) construction and fully sprinklered. The facility has a fire alarm system with smoke	K 0000	This Plan Of Correction constitutes the written allegation of compliance for deficiencies cited. The submission of this Plan of Correction is not an admission that a deficiency exists or that it was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law.	

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	detection in the corridors, spaces open to the corridors, battery operated smoke detectors in all resident rooms in the building. The facility has a capacity of 101 and had a census of 69 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except for two detached garages used for storage which were not sprinklered. Quality Review completed on 04/15/24			
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 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			

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	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 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	K 0222	**K222 Egress Doors**	05/09/2024

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	failed to ensure 2 of over 6 delayed egress locking arrangements was installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect 35 residents if needing to exit the facility. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director (MD), Administrator and Maintenance Facility Support staff on 04/09/24 between 12:15 p.m. and 2:30 p.m., the (1) Exit door from the lounge on the 300 Hall and (2) the Therapy Exit on the 300 Hall each equipped with a 15 second delayed egress failed to actuate when tested. When the exit doors were tested the irreversible process to release the lock was not initiated. Based on interview at the time of observation, the Surveyor and Maintenance Facility Support staff tried 3 times unsuccessfully to activate each of the delay egress mechanisms. This finding was acknowledged by the MD at the		**What Corrective Action will be accomplished for those residents found to have been affected by this deficient Practice:** No residents were affected by this practice. The contracted company will be called to modify doors to acceptable standards. Elwood Fire arrived on 4/18/2024 to adjust egress doors to place in compliance. Attachment # 2 **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken:** All residents have the potential to be affected by incorrect egress irreversible process that was not engaging in appropriate time. All egress doors will be tested for correct release of lock within required times weekly. Monitoring will be logged into the Maintenance Director TELS system. Any deficiencies will be reported to the Administrator asap and contractor notified to perform service call. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur.** Weekly testing will be done for all delayed egress doors weekly by Maintenance director or designee. Test results will be entered into TELS system. Any deficient	

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	time of discovery and again by the Maintenance Director (MD), Administrator and Maintenance Facility Support person at the exit. 3.1-19(b)		mechanisms will be reported to administrator and contracted services will be called to perform service call. Will be reviewed at QAPI meeting to ensure compliance. **How will the corrective action be monitored to ensure the deficient practice will not recur:** Weekly testing will be conducted on each egress door to ensure the mechanism is in correct working order. This will ensure the safety of residents and staff if emergency exits are needed. Testing will be monitored in TELS system for compliance. Documentation will be submitted to the Administrator weekly for review. Practice and documentation will be reviewed at monthly QAPI meeting to ensure compliance and continued monitoring at QAPI for at least 6 months	
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review, observation and interview; the facility failed to document 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,	K 0291	**K291 Emergency Lighting** **What Corrective Action will be accomplished for those residents found to have been affected by this deficient Practice:**	05/09/2024

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	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 over 15 residents, staff and visitors. Findings include: Based on records review and interview with the Maintenance Director (MD), Administrator and Maintenance Facility Support staff on 04/09/24 between 10:00 a.m. and 12:15 p.m., annual 90-minute testing documentation for all battery backup lights was not available for review. Monthly testing documentation was available for the battery backup lights. Two lights were observed in the Kitchen Dining area and at the Generator. The Maintenance Facility Support staff stated that he was new to the facility but didn't believe a completed 90-minute test of the emergency lights was completed within the past year. This finding was acknowledged by the MD at the time of discovery and again by the Maintenance Director (MD), Administrator and Maintenance Facility Support person at the exit.		90 Minute light testing has been completed. Task has been added to TELS system as reminder to Maintenance Director for annual testing. Attachment #3 will be used as proof of testing. **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken:** Two lights were noted as not having annual testing completed. Both battery backup lights have been tested and added to the annual TELS reminder/documentation. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur.** Annual testing dates have been added to TELS system for annual reminder as well as documentation of task done. Test has been completed and document submitted to Administrator. **How will What Corrective Action will be accomplished for those residents found to have been affected by this deficient Practice:** Corrective action was completing test with documentation, annual testing date is added to TELS system to ensure Maintenance Director will be notified when test is due. Completion of test will be	

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	3.1-19(b)		documented into TELS systems to ensure compliance. This will ensure lights work as needed. Documentation will be submitted to the Administrator weekly x 1 month, then monthly x 3 months to ensure compliance is achieved. Documentation and performance will be reviewed at monthly QAPI meetings for at least 6 months.	
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 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 install the kitchen range hood system in accordance with the requirements of LSC 9.2.3.	K 0324	K324 Cooking Facility (SSE) **What Corrective Action will be accomplished for those**	05/09/2024

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	Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 edition, Section 6.2.4.1 states kitchen range hood system filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). This deficient practice could affect up to 6 staff and visitors. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director (MD), Administrator and Maintenance Facility Support staff on 04/09/24 between 12:15 p.m. and 2:30 p.m., in the kitchen, the design of the kitchen hood requires one drip tray. The required drip tray on the right side was missing at the time of the survey. This finding was acknowledged by the MD at the time of discovery and again by the Maintenance Director (MD), Administrator and Maintenance Facility Support person at the exit. 3.1-19(b)		**residents found to have been affected by this deficient Practice:** Drip tray was immediately replaced by Maintenance Supervisor. Drip tray will be monitored daily to ensure proper placement. Attachment #4 **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken:** Staff and visitors would be affected by deficient practice. Daily monitoring for proper placement of drip tray will be done M-F by Maintenance Supervisor, weekend monitoring will be done by day shift cook in dietary. The drip tray was immediately replaced. Dietary staff were educated on importance of maintaining compliance with drip tray being in place. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur.** Daily audit to ensure drip tray in place for compliance. Placement will be checked daily by Maintenance staff Monday through Friday, with dietary cook auditing on weekend. Attachment #3. **How will the corrective action be monitored to ensure the deficient practice will not recur:**	

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			Audit sheet implemented to verify daily audit for proper placement of drip tray. Results will be shared with the Administrator and shared at monthly QAPI for at least 6 months.	
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 1. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be	K 0353	**K 353 Sprinkler System -Maintenance and Testing** **What Corrective Action will be accomplished for those residents found to have been affected by this deficient Practice:** *Testing has been completed but do not have documentation to support it. TELS system updated to document testing per regulation. Attachment #7	05/09/2024

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	inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly, or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director (MD), Administrator and Maintenance Facility Support staff on 04/09/24 between 10:00 a.m. and 12:15 p.m., there was no weekly inspection records of the dry pipe sprinkler system's gauges and valves for the past year. During an interview at the time of record review, the Maintenance Director stated the inspection of gauges and valves had been done but no records had been kept. The MD stated that he was aware of the requirement to keep records and had been reminded by another inspector, but he just forgot to record the pressures when he inspected the gauges. This finding was acknowledged by the MD at the time of discovery and again by the Maintenance Director (MD), Administrator and Maintenance Facility Support person at the exit. 2. Based on observation and interview, the facility failed to maintain the ceiling construction of 1 of 1 smoke compartment. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice affects 2 staff.		* 2 foot x 2 foot hole in ceiling in Maintenance office due to water leakage has been repaired. Attachment # 5 **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken:** All residents could be affected by this practice. Testing has been completed per regulation, but it was not documented. TELS system has been updated to ensure documentation compliance is upheld. 2 foot by 2 foot hole in Maintenance office had potential to affect staff members, Hole has been repaired as seen in attachment #5. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur.** Required testing has been added to TELS system to ensure accurate documentation is completed after each test. Documentation will be audited by the Administrator weekly x 4 weeks, monthly x 4 months to ensure compliance. Hole in Maintenance office has been repaired. Attachment # 5 **How will the corrective action be monitored to ensure the deficient practice will not recur:**	

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	Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director (MD), Administrator and Maintenance Facility Support staff on 04/09/24 between 12:15 p.m. and 2:30 p.m., in the Maintenance Supervisors Office approximately a 2 foot by 2 foot hole was visible in the ceiling. The hole was covered with plastic. The MD stated that is was from a water issue a few months ago. This finding was acknowledged by the MD at the time of discovery and again by the Maintenance Director (MD), Administrator and Maintenance Facility Support person at the exit. 3.1-19(b)		Corrective actions will be monitored by Administrator weekly x 4 weeks, monthly x4 months then monthly at QAPI meeting to assures documentation compliance. Will be reviewed at monthly QAPI meeting and for at least 6 months to ensure compliance. Repair is completed in Maintenance office hole in ceiling as seen in attachment #4.	
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 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			

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	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 all corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 8 staff and 15 residents. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director (MD), Administrator and Maintenance Facility Support staff on 04/09/24 between 12:15 p.m. and 2:30 p.m., the following corridor doors failed to latch positively into their respective door frames and would not resist the passage of smoke: a) Pantry door into the corridor, equipped with a self-closing device.	K 0363	**K363 Corridor-Doors** **What Corrective Action will be accomplished for those residents found to have been affected by this deficient Practice:** All affected doors have been mechanically adjusted to close properly. 100 soiled utility room that had cart obstructing closing has been relocated and door to be monitored daily to prevent being propped open. Attachment #6. Gap around Covid Closet has been repaired with plate to eliminate gap. **How will other residents having the potential to be affected by**	05/09/2024

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	b) 100 Hall Soiled Utility door was obstructed from closing and latching with a cart. c) The Linen storage closet door (1 of 2 side by side) on the 300 Hall. d) The double door set in the corridor on the 200 Hall, equipped with a self-closing device and latching hardware, failed to latch positively when tested multiple times by the surveyor and MD. e) The corridor door to the Covid Closet near the Mechanical Room had approximately a ½ inch gap around the doorknob not allowing the door to resist the passage of smoke when in the closed position. This finding was acknowledged by the MD at the time of discovery and again by the Maintenance Director (MD), Administrator and Maintenance Facility Support person at the exit. 3.1-19(b)		**the same deficient practice be identified and what corrective action will be taken:** All automatic closing doors will be audited weekly to ensure self-closing is working appropriately. This weekly audit has been added to the TELS system to ensure compliance. Daily audits will be performed daily to ensure not carts or other devices will be propped in doors to keep doors from closing. Audits will be done by the Maintenance Director or designee to ensure doors are able to close correctly. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur.** Daily audits will be done to all self-closing doors to ensure proper closing is engaged. During audit, performed by Maintenance Director or designee will be completed daily M-F to ensure compliance with closing. **How will the corrective action be monitored to ensure the deficient practice will not recur:** Daily audits will be performed daily M-F by Maintenance Director or designee to ensure doors are closing properly and not obstructions that would permit doors from closing. Audits will be done daily M-F x 4 weeks by Maintenance Director or designee.	

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			Results will be discussed with the Administrator. When compliance is achieved, doors will be checked weekly to ensure compliance. Results will be presented to and discussed at the monthly QAPI meeting and monthly for 6 months.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure electrical outlets were protected in the 300 Hall according to 19.5.1. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect 20 residents, staff and visitors on the 300 Hall. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director (MD), Administrator and Maintenance Facility Support staff on 04/09/24 between 12:15 p.m. and 2:30 p.m., the following locations were missing covers over the electrical outlets or junction boxes:	K 0511	**K511 Utilities – Gas and Electric** **What Corrective Action will be accomplished for those residents found to have been affected by this deficient Practice:** Rooms that are noted on inspection are rooms that contractors are repairing due to a large water leak. Contractors have been educated on the importance of outlet covers being installed and junction boxes being covered. Deficit practice remediated quickly. When contractors are in the building, the Maintenance Supervisor or designee will complete walk through at the end of the workday to ensure all electrical outlets are in	05/09/2024

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	A) The corridor outside RR# 310 - had a junction box with exposed wire missing a cover. B) RR # 305, 310 and 304 each had outlets and switches which were missing covers. This finding was acknowledged by the MD at the time of discovery and again by the Maintenance Director (MD), Administrator and Maintenance Facility Support person at the exit. 2. Based on observation and interview, the facility failed to ensure all electrical panels in the corridors were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect 15 staff and residents. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director (MD), Administrator and Maintenance Facility Support staff on 04/09/24 between 12:15 p.m. and 2:30 p.m., one electrical panel in the corridor near the Maintenance Office was unlocked when tested.		compliance**. Attachment #6** The electrical panel outside of the maintenance office was locked immediately. Daily audits to ensure compliance. **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken:** The rooms noted during inspection were empty due to construction. The junction box in the corridor has been covered to prevent further risk. Attachments #8,9,10,11 and 12. Contractors have been trained and the Maintenance Supervisor will do daily walk through at end of business to ensure all outlets and junction boxes are in compliance. Electrical panel outside of Maintenance office has been locked and will remain locked unless being used. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur.** Education given to contractors and reminders will be issued when contractors are working in the building. Maintenance Supervisor or designee will audit outlets and junction boxes daily at end of day when contractors are working in building to ensure compliance. Electrical panels will be audited daily to ensure lock is engaged.	

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	This finding was acknowledged by the MD at the time of discovery and again by the Maintenance Director (MD), Administrator and Maintenance Facility Support person at the exit. 3.1-19(b)		**How will the corrective action be monitored to ensure the deficient practice will not recur:** Education will be given to contractors to review the need for compliance. A daily walk-through will be done at the end of the day to ensure contractors have left outlets and junction boxes to be in compliance. Results will be presented to the Administrator weekly as well as if the contractors do not perform as required. Compliance will be discussed at monthly QAPI meetings. Electrical panels will be locked unless being used. This will be audited daily X 4 weeks by Maintenance Supervisor or designee. After compliant for 4 weeks, weekly audit will be completed weekly x 4 weeks. Attachement #6 Compliance will be discussed at monthly QAPI meeting and continues review for at least 6 months.	
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)			
	Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 facility's diesel-powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test	K 0918	**K918 Electrical Systems** **What Corrective Action will be accomplished for those residents found to have been affected by this deficient Practice:** Annual fuel quality test was performed on 7/23/2023. Document was not available when surveyor was performing inspection. Attachment #1 **How will other residents having**	05/09/2024

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	shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on records review and interview with the Maintenance Director (MD), Administrator and Maintenance Facility Support staff on 04/09/24 between 10:00 a.m. and 12:15 p.m., no documentation of an annual fuel quality test for the diesel generator was available for review. The facility has 1 Diesel fired generator. Based on interview at the time of records review, the fuel quality testing for the diesel fired generator could not be located. The MD reached out to the company that services the generator, but no documentation was available for review. This finding was acknowledged by the MD at the time of discovery and again by the Maintenance Director (MD), Administrator and Maintenance Facility Support person at the exit. 3.1-19(b)		**the potential to be affected by the same deficient practice be identified and what corrective action will be taken:** No residents have the potential to be affected by this same practice due to testing done in timely manner, shown in attachment #1. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur.** Dates have been entered into the Maintenance Director TELS system to receive alerts when testing will be done. Documentation that annual test has been completed will be copied and placed in binder of required documentation in Maintenance Director office. **How will the corrective action be monitored to ensure the deficient practice will not recur:** The Maintenance Director will copy Administrator on receipt of annual fuel quality test results upon receipt. Next annual fuel quality test is scheduled and tagged in TELS system. Will be reviewed at QAPI meeting to ensure compliance and continue for at least 6 months.	