STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155532	A. BUILDING -- B. WING	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BLOOMINGTON NURSING AND REHABILITATION CENTER	120 E MILLER DR BLOOMINGTON, IN 47401

(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: 01/04/23 Facility Number: 000460 Provider Number: 155532 AIM Number: 100290620 At this Emergency Preparedness survey, Bloomington Nursing and Rehabilitation Center was found in substantilal compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 38 certified beds and had a census of 27 at the time of this visit. Quality Review completed on 01/05/23	E 0000	Bloomington By submitting the enclosed material, we are not confirming the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings as part of any proceedings and submit this response pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective February 10 2023 for the life safety audit completed on January the 4th 2023. The facility is requesting a desk review	
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Faith Arvin	Administrator	01/19/2023

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

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	155532	A. BUILDING -- B. WING	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BLOOMINGTON NURSING AND REHABILITATION CENTER	120 E MILLER DR BLOOMINGTON, IN 47401

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	Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to develop and maintain an emergency	E 0004	Bloomington By submitting the enclosed	02/10/2023

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	155532	A. BUILDING -- B. WING	01/04/2023

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	preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Disaster Plan on 01/04/23 from 9:40 a.m. to 12:55 p.m. with the Maintenance Director, the emergency plan available has not been reviewed within the past 12 months due to no date being found in the plan. Based on interview with the Administrator, she agreed there was no annual review date provided for the Emergency Preparedness plan at the time of the survey. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.		material, we are not confirming the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings as part of any proceedings and submit this response pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective February 10 2023 for the life safety audit completed on January the 4th 2023. The facility is requesting a desk review E004 The facility develops and implements emergency preparedness plans and are evaluated and updated at least annually Disaster plan has been reviewed and updated if needed with the date of review documented. All residents have the potential to be affected by this finding. The maintenance director received in service education on requirement for the disaster plan to be kept current and reviewed at a minimum annually. The administrator will monitor the emergency preparedness plans including but not limited to the disaster plan monthly times six months. The findings of the monitoring will be reported to the QAPI committee monthly by the maintenance director or his	

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			designee. if 100% compliance has not been achieved this will continue until the threshold has been met. Completion date 2/10/2023	
E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency 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			

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	155532	A. BUILDING -- B. WING	01/04/2023

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	be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are 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	E 0013	E013	02/10/2023

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	failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's Disaster Plan on 01/04/23 from 9:30 a.m. to 12:55 p.m. with the Maintenance Director, the emergency plan available did not have a review date during the past 12 month period. Based on interview with the Administrator, she agreed there was no annual review date provided for the Emergency Preparedness plan at the time of the survey. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.		The facility develops and implements emergency preparedness policies and procedures. The policies and procedures for emergency preparedness were reviewed, dated, and updated if needed, according to the facilities current set. All residents have the potential to be affected by this finding. The maintenance director received in service education on the necessity for the emergency preparedness programs and policies and procedures to be kept current, reviewed, and dated accordingly, a minimum of annually. The Administrator or designee will monitor the emergency preparedness monthly times six months. The finding will be reported to the QAPI committee by the Administrator or her designee.. if 100% compliance has not been achieved this will continue until the threshold has been met. Completion date 2/10/2023	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c),			

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	§485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Disaster Plan on 01/04/23 from 9:30 a.m. to 12:55 p.m. with the Maintenance Director, the emergency plan available did not have a review date during the past 12 month period. Based on interview with the Administrator, she agreed there was no annual review date provided for the Emergency Preparedness plan at the time of the survey. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.	E 0029	E029 The facility develops and maintains an emergency preparedness communication plan that complies with the federal, state and local laws. The current disaster plan was reviewed, updated if needed and dated, including the emergency preparedness communication plan. All residents have the potential to be affected by this finding. The maintenance director received in service education on the necessity for the disaster plan to be kept current, dated and reviewed at least annually. The administrator will monitor the emergency preparedness review to assure it is reviewed annually, including an emergency preparedness communication plan. The findings of the monitoring will be reported to the QAPI committee monthly. If 100% compliance has not been achieved this will continue until threshold has been met completion date 2/10/2023	02/10/2023

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E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the			

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	communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants.	E 0036	E036 The facility develops and maintains an emergency preparedness training and testing program that is based on the emergency plan. The training and testing program	02/10/2023

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	Findings include: Based on review of the facility's Disaster Plan on 01/04/23 from 9:30 a.m. to 12:55 p.m. with the Maintenance Director, documentation of an updated training and testing program reviewed by the facility within the most recent twelve-month period was not available for review. Based on interview with the Administrator, she agreed there was no annual review date provided for the training and testing plan at the time of the survey. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.		has been reviewed, dated and updated if needed. All residents have the potential to be affected by this finding. The maintenance director received in service education on the necessity for the training and testing program to be reviewed, dated and updated if needed at least annually. The Administrator or designee will monitor that the training and testing program has been reviewed, dated and updated and least annually, monthly times six months. The finding will be reported to the QAPI committee times six months. if 100% compliance has not been achieved this will continue until the threshold has been met. Completion date 2/10/2023	
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: 01/04/23 Facility Number: 000460 Provider Number: 155532 AIM Number: 100290620 At this Life Safety Code survey, Bloomington Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation	K 0000	Bloomington By submitting the enclosed material, we are not confirming the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings as part of any proceedings and submit this response pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective February 10 2023 for the life safety audit completed on January the	

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	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 II (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 38 and had a census of 27 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except two detached sheds used for facility storage. Quality Review completed on 01/05/23		4th 2023. The facility is requesting a desk review	
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 observation and interview, the facility failed to ensure all battery powered emergency lights were maintained in accordance with LSC 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. LSC 7.9.2.7 states the emergency lighting system shall be	K 0291	**K291** The facility strives to ensure that all battery powered emergency lights are maintained in accordance with the regulation. The battery-operated emergency light outside of the exit was removed as there are other lights above functioning properly. Residents that use this exit have the potential to be affected by this	02/10/2023

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	either be continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect residents and staff using the side exit. Findings include: Based on observation with the Maintenance Director at 1:05 p.m. on 01/04/23 during a tour of the facility, the battery operated emergency light outside the side exit failed to function when its respective test button was pushed three times. Based on interview at the time of observation, the Maintenenance Director stated battery operated lights in the facility are tested monthly, and confirmed the aforementioned battery operated emergency light failed to function when its respective test button was pushed. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		finding. The maintenance director received in service education of the necessity to ensure emergency lighting is functioning properly. The Administrator or designee will monitor that the emergency lighting system is functioning according to the rule 5 days a week x 1 month, weekly x 1 month, then monthly x 4 months the findings will be reported to the QAPI committee monthly. If 100% compliance has not been achieved this will continue until the threshold has been met Completion date 2/10/2023	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 1. Based on record review, interview and observation, the facility failed to ensure documentation for the preventative maintenance of 18 of 18 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious	K 0300	**K300** The facility ensures documentation for the preventive maintenance of battery operated smoke alarms in resident rooms is completed.	02/10/2023

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BLOOMINGTON NURSING AND REHABILITATION CENTER	120 E MILLER DR BLOOMINGTON, IN 47401

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	to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of the Battery Operated Detector reports on 01/04/23 from 9:30 a.m. to 12:55 p.m. with the Maintenance Director present, there was no itemized list of resident room battery operated smoke alarms tested for functionality on a monthly basis during the past twelve months. Based on interview at the time of review, the Maintenance Director agreed the battery-operated smoke detector testing documentation was not itemized by location. Based on observations between 12:55 p.m. and 1:45 p.m. during a tour of the facility with the Maintenance Director, battery operated smoke alarms were observed in all 18 resident sleeping rooms. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 2. Based on observation and interview; the facility failed to ensure all battery-operated smoke alarms in resident rooms were maintained. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 29.10 states fire-warning equipment shall be maintained and		Itemized list of resident room battery operated smoke alarms was updated to ensure functionality testing is completed monthly with documentation of such for each alarm. All smoke detectors were discarded and replaced with new ones. The itemized room list will include the manufacturers date of each current alarm. The maintenance director received in service education to ensure that an itemized list is kept, showing that the smoke detectors are tested monthly with documentation on each, individual alarm as well as assuring alarms are not greater than 10 years old. The administrator or designee will monitor monthly x 6 months that the smoke detectors are being tested monthly and documented individually, per the itemized list and that the manufacturer's date is included on the list, and the batteries are changed annually. The findings of the monitoring will be reported to the QAPI committee monthly. If 100% compliance has not been achieved this will continue until the threshold has been met. Completion date 2/10/2023	

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	tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. Section 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observation during a tour of the facility with Maintenance Director on 01/04/23 at 1:28 p.m., the battery-operated smoke detector mounted on the ceiling in resident room #3 was inspected. This smoke detector was manufactured on February 11, 2012 and was more than 10 years old. Based on interview with the Maintenance Director at the time of the above-mentioned observation, the Maintenance Director stated that he was unaware of the manufactured date of the single action smoke alarm and he would check every battery operated smoke alarms in all resident rooms to make sure they did not need to be replaced because they were more than 10 years old. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(c)			
K 0345 SS=F	NFPA 101 Fire Alarm System - Testing and			

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Bldg. 01	Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 01/04/23 between 9:30 a.m. and 12:55 p.m. with the Maintenance Director, documentation was provided for a visual semi-annual fire alarm system inspection on 07/07/22, however the initiating devices were not itemized. Based on interview at the time of record review, the Maintenance Director stated he was	K 0345	**K345** The facility maintains the fire alarm system in accordance with the rule. A visual inspection of the fire alarm system was completed on 1/19/2020 with an itemized listing of initiating devices. All residents have the potential to be affected by this finding. The maintenance director received in service education on the necessity for the visual inspection of the fire alarm system that must be done semiannually to include an itemized listing of initiating devices. The Administrator or designee will monitor the semiannual visual on the fire alarm system monthly times six months. The finding of the monitoring will be reported to the QAPI committee monthly. If 100% compliance has not been achieved this will continue until the threshold has been met Completion date 2/10/2023	02/10/2023

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	not aware that the semi-annual visual inspection needed to be itemized. Based on record review on 01/04/23, the annual fire alarm testing was conducted on 04/15/22. This finding was reviewed with the Administrator and Maintenance Director at 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 conduct quarterly fire drills at unexpected times under varying conditions for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of Direct Supply TELS Logbook Documentation: "Fire Drills" with the Maintenance Director during record review from 9:30 a.m. to 12:55 p.m. on 01/04/23, first shift fire drills conducted within the most recent twelve month period on 04/06/22, 07/07/22 and 10/12/22 were conducted at, respectively, 10:00 a.m., 10:20	K 0712	K712 The facility conducts fire drills at unexpected times under varying conditions on every shift at least quarterly. The fire drill for third shift was conducted immediately. All residents have the potential to be affected by this finding. The maintenance man received in service education on the necessities to conduct fire drills quarterly, on each shift at unexpected times under varying conditions.	02/10/2023

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	a.m. and 10:55 a.m. Second shift fire drills conducted within the most twelve month period on 02/08/22, 05/23/22 and 10/22/22 were conducted at, respectively, 6:15 p.m., 6:00 p.m., and 6:15 p.m. Based on interview at the time of record review, the Maintenance Director stated the facility operates two shifts per day from 6:00 a.m. to 6:00 p.m. and agreed the aforementioned fire drills were not conducted at unexpected times under varying conditions. Furthermore, fire drills conducted within the most recent twelve month period on 03/11/22 at 6:30 p.m., 10/22/22 at 6:15 p.m. and 12/23/22 at 1:00 p.m. were all marked as third shift drills. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		A calendar has been completed to aid in monitoring random dates and times. The administrator or designee will monitor that the fire drills are being completed as required. this monitoring will be conducted monthly times six (6) months. The findings of the monitoring will be reported to the QAPI committee monthly. If 100% compliance has not been achieved this will continue until the threshold has been met. Completion date 2/10/2023	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.			

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	(3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview; the facility failed to ensure 1 of 1 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect at least 6 residents and staff in the designated smoking area. Findings include: Based on observation with the Maintenance Director on 01/04/23 at 1:09 p.m. during a tour of the facility, outside the back exit by resident room 11 where the designated smoking area is located, there were over 20 cigarette butts disposed on the ground along the sidewalk in among leaf litter by the smoking area. Based on interview at the time of observation, the Maintenance Director agree there were cigarette butts on the ground in the designated smoking area. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0741	K741 The facility ensures that smoking areas are maintained by disposing cigarette butts into a metal or noncombustible container with self-closing covered devices. All the cigarette butts were cleaned up immediately. All residents have the potential to be affected by this finding. A in service education was provided to all staff and residents (who smoke) regarding using the proper receptacles for discarding cigarette products As part of the groundskeeping maintenance has posted signs to assist those in disposing of their cigarettes in approved container maintenance will add this finding to his preventative maintenance The Administrator or designee will monitor that cigarette butts and like products are disposed of in the containers 5 days a week times 4 weeks, biweekly times 4 weeks, and then monthly	02/10/2023

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			thereafter times 4 months. The findings of the monitoring will be reported to the QAPI committee monthly. If 100% compliance has not been achieved this will continue until the threshold has been met Completion date 2/10/23	
K 0914 SS=C Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and interview, the facility failed to ensure electrical receptacles at 18 of 18 resident sleeping rooms	K 0914	**K914** The facility ensures electrical receptacles are tested at least	02/10/2023

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	were tested at least annually for non-hospital receptacles and initially for hospital grade receptacles. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 01/04/23 between 12:55 p.m. and 1:45 p.m., the facility's resident sleeping rooms contained three to four electrical receptacles with a mix of hospital and non-hospital grade receptacles. Based on records review at from 9:30 a.m. to 12:55 p.m., there was documentation available to show seven resident sleeping room receptacles were tested on 06/09/2022, but the receptacle testing for the remaining rooms were not documented. Based on interview at the time of the observation and records review, the Maintenance Director stated some of the the receptacles were tested but did not have complete documentation. This finding was reviewed with the Administrator		annually. Receptacle testing has been done in all rooms, including a visual inspection of each receptacle's physical integrity. An itemized list of each receptacle was created with documentation to be done on each receptacle verifying when testing completed. Testing to include verifying the continuity of the grounding circuits, correct polarity of the hot and neutral connections and retention force of the grounding blade of each receptacle (except locking-type receptacles) is not less than 115 grams (4 ounces). All residents have the potential to be affected by this finding. The maintenance director received in service education on the necessities of testing and documenting. the electrical receptacles according to the regulation. The Administrator or designee will monitor tracking of the electrical receptacle testing monthly x 6 months. The findings of the monitoring will be reported to the QAPI committee monthly. If 100% compliance has not been achieved this will continue until the threshold has been met Completion date 2/10/2023.	

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	and Maintenance Director during the exit conference. 3.1-19(b)			