STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155495	A. BUILDING -- B. WING	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PADDOCK SPRINGS	2695 SHELDON STREET WARSAW, IN 46582

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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: 08/29/22 Facility Number: 000491 Provider Number: 155495 AIM Number: 100291230 At this Emergency Preparedness survey, Paddock Springs, was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 60 certified beds. At the time of the survey, the census was 54. Quality Review completed on 09/08/22	E 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey visit with exit on August 29, 2022. **E-004 – Develop EP Plan, Review and Update Annually** Compliance Date – 9/23/22 **Immediate Intervention** The Executive Director has updated the Emergency Operations Plan for both locations – Nurse station and maintenance office. The Executive Director was educated by Facilities Management Support on E004 Develop EP plan, review, and update annually. The facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. The Executive Director will audit the Emergency preparedness	

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

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			communication 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants. **E-013 – Development of EP policies and procedures** Compliance Date – 9/23/22 **Immediate Intervention** The Executive Director has updated the Policies and Procedures to include emergency services in the Emergency Operations Plan for both locations – Nurse station and maintenance office. The Executive Director was educated by Facilities Management Support on E013 Development of EP Policies and Procedures. The LTC facility must develop and implement emergency preparedness and polices 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. The Executive Director will audit	

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			the Emergency preparedness communication 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants. **E-029 – Development of Communication Plan** Compliance Date – 9/23/22 **Immediate Intervention** The Executive Director has removed out date policies and updated the Emergency Operations Plan located at the Nurse station. The Executive Director was educated by Facilities Management Support on E029 Develop EP plan, review, and update annually. The facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. The Executive Director will audit the Emergency preparedness communication 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue	

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			until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants. **E-031 – Emergency Officials contact Information** Compliance Date – 9/23/22 **Immediate Intervention** The Executive Director has updated the Emergency Operations Plan to include contact information for ombudsman located at all locations. The Executive Director was educated by Facilities Management Support E031, Emergency Officials Contact Information to include Federal, State, Tribal, Regional, and local emergency preparedness staff. The State Licensing and Certification Agency. The Office of the State Long-Term Care Ombudsman, Other sources of assistance. The Executive Director will audit the Emergency preparedness officials contact information 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the	

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			potential to affect all occupants. **E-036 – Training and Testing** Compliance Date – 9/23/22 **Immediate Intervention** The Executive Director has updated the Training and Testing plan for the Emergency Operations Plan located at the Nurse station. The Executive Director was educated by Facilities Management Support on E036 Develop EP plan, review, and update annually to include Training and Testing (483.73(d). The facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. The Executive Director will audit the Emergency preparedness training and testing 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants. **E-039 -Testing Requirements** Compliance Date – 10/5/22 **Immediate Intervention** The Executive Director has	

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			completed the facilities-based tabletop exercise and has scheduled a community-based exercise to be completed by 10/5/22. The Executive Director was educated by Facilities Management Support on E039 Testing Requirements 483.73(d) The facility must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drill using the emergency procedures. The Executive Director will audit the Emergency preparedness testing requirements 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants. **E-041– LTC Emergency Power** Compliance Date – 9/23/22 **Immediate Intervention** The Director of Plant Operations conducted a monthly load for the generator The Executive Director and Director of Plant Operations was educated by the Facilities Management Support on E041 LTC Emergency Power. The LTC	

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			Facility must implement the emergency power system inspection, testing, and requirements found in the NFPA 110. The Executive Director will audit the Emergency preparedness LTC emergency power 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants. **K-131 – Multiple Occupancies** Compliance Date – 9/23/22 **Immediate Intervention** The Director of Plant Operations has acquired the appropriate documentation showing the window in the 90 – minute fire rated door was provided with a fire rated – glazing material. The Director of Plant operations was educated by the Executive Director on K131 Multiple Occupancies, LSC 8.3.3 Section 8.3.3.12 states new fire protection – rated glazing shall be marked in accordance with Table 8.3.3.12 and Table 8.3.4.2, and such marking shall be permanently affixed. The Director of Plant Operations	

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			will audit the deficient window located in the 90-minute rated door for appropriate glazing material 1 X per week X 6 weeks. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect 20 residents in one smoke compartment. **K-211 – Means of Egress** Compliance Date – 9/19/22 **Immediate Intervention** The Director of Plant Operations removed food serving equipment, two soiled linen carts, boxes, and furniture stored in the Service Hall corridor. The Director of Plant Operations was educated by the Executive Director on K211 – Means of Egress – General. Aisles, passageways, corridor's, exit discharges, exit locations, and access are in accordance with Chapter 7 The Director of Plant Operations will audit the Service Hall corridor for obstructions impeding the path of egress 1 X per week X 6 weeks. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue	

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			until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice would affect staff using the Service Hall exit. **K-222 – Egress Doors** Compliance Date – 9/19/22 **Immediate Intervention** The Director of Plant has installed signage indicating that the exit door located on 300 hall could be opened in 15 seconds by pushing on the doors. The Director of Plant Operations was educated by the Executive Director on K22, Means of Egress, LSC 7.2.1.6.1 (3)(4) states a readily visible, durable sign in letters not less than 1 in. high and not less than 1/8 in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress. “PUSH UNTIL ALARMSOUNDS. DOOR CAN BE OPENED IN 15 SECONDS” The Director of Plant Operations will audit the deficient door on the 300 hall for appropreait signage 1 X per week X 6 weeks X 2 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	

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			This deficient practice could affect 15 residents in the 300 -hall K-324 – Cooking Facilities Compliance Date – 9/19/22 **Immediate Intervention** The Director of Plant Operations and Kitchen staff have clean the kitchen hood removing the oily sludge. The Hood Cleaning Contractor was scheduled for quarterly cleanings of the hood system. The Director of Plant Operations was educated by the Executive Director on K324, Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial cooking Operations. The Director of Plant Operations will audit the kitchen hood for cleanliness 1 X per day X 4weeks X 1 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect at least 30 residents in the dining room and kitchen staff. **K-341 – Fire Alarm System – Installation** Compliance Date – 9/23/22	

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			Immediate Intervention The Director of Plant Operations contacted contractor to move the smoke detector located in the breakroom with a minimum of 36in. from the air supply. The Director of Plant Operations was educated by the Executive Director on K341, Fire Alarm System – installation. A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code. The Director of Plant Operations will audit the smoke detector in the breakroom for location 1 X per week X 4weeks X 1 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect staff in the breakroom. **K-351 – Sprinkler System - Installation.** Compliance Date – 9/23/22 **Immediate Intervention** The Director of Plant Operations has contacted Contractor to have the sprinkler head moved and extended.	

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			The Director of Plant Operations was educated by the Executive Director on K351, Sprinkler System – Installation. Buildings are to be protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the installation of sprinkler systems. The Director of Plant Operations will audit the deficient sprinkler head located in dining room for proper installation 1 X per week X 4weeks X 1 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all residents. **K-353 – Sprinkler System – Maintenance and Testing** Compliance Date – 9/23/22 **Immediate Intervention** The Director of Plant Operations has contacted contractor to replace the deficient gauge on the sprinkler system. The Director of Plant Operations was educated by the Executive Director on K353, Sprinkler System – Maintenance and Testing Automatic sprinkler and standpipe systems are inspected tested and maintained in	

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			accordance with NFPA 25. The Director of Plant Operations will audit the sprinkler gauge for proper inspection and date 1 X per week X 4weeks X 1 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all residents, staff, and visitors in the facility. **K-363 – Corridor – Doors** Compliance Date – 9/19/22 **Immediate Intervention** The Director of Plant Operations removed the door wedge propping the Therapy door open. The Director of Plant Operations was educated by the Executive Director on K363, 18.3.6.3 There is no impediment to the closing of the doors. The Director of Plant Operations will audit Therapy for wedges that could prop door open 1 X per week X 4weeks X 1 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect	

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			6 residents in Therapy gym. **K-372 – Subdivision of Building Spaces – Smoke Barrier Construction** Compliance Date – 9/19/22 **Immediate Intervention** The Director of Plant Operations has made repairs to the two penetrations located 100 hall smoke barriers. The Director of Plant Operations was educated by the Executive Director on K363, NFPA 101, 2012 edition Smoke barriers shall be constructed to provide at least a 1-hour fire resistance rating and constructed in accordance with 8.5 The Director of Plant Operations will audit smoke barrier located on 100 for penetrations 1 X per week X 4weeks X 1 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect 20 residents in two smoke compartments. **K-379 – Smoke Barrier Door Glazing** Compliance Date – 9/23/22 **Immediate Intervention**	

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			The Director of Plant Operations has acquired the appropriate documentation showing the window in 5 of 5 smoke barrier doors with windows was provided with a fire rated – glazing material. The Director of Plant Operations was educated by the Executive Director on K379, Smoke Barrier Door Glazing. Windows in smoke barrier doors shall be installed in each cross-corridor swing or horizonal-sliding door protected by fire – rated glazing or by wired glass panels in approved frames. 18.3.7.9 The Director of Plant Operations will audit the 5 of 5 smoke barrier doors for fire rated glazing 1 X per week X 4weeks X 1 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all residents. **K-712 – Fire Drills** Compliance Date – 9/23/22 **Immediate Intervention** The Director of Plant Operations has conducted a fire drill for each shift The Director of Plant Operations was educated by the Executive Director on K712, Fire drills,	

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			NFPA 101, Fire Drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The Executive Director will audit/review each fire drill with the Director of Plant Operations 1 X Month X 3 Months Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all staff and residents. **K-754 – Soiled Linen and Trash Containers** Compliance Date – 9/23/22 **Immediate Intervention** The Director of Plant Operations has removed the two 30-gallon soiled linen carts that are side by side in the service hall corridor. The Director of Plant Operations was educated by the Executive Director on K754, Soiled Linen and Trash Containers, soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The Director of Plant Operations will audit the service hall for the storage of soiled linen carts assuring this does not exceed more than 32 gallons within 64 sq feet 1 X per day X 4weeks X 1 months.	

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			Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all staff in service hall. **K-918 – Electrical Systems – Essential Electrical System Maintenance and Testing.** Compliance Date – 9/22/22 **Immediate Intervention** The Director of Plant Operations has exercised the generator set for a minimum of 30 minutes and documented. The Director of Plant Operations was educated by the Executive Director on K918, NFPA 101 Electrical System Essential Electrical System Maintenance and Testing. Generator sets are inspected weekly, exercised under load 30 minutes 12 times per year in 20–40-day intervals, and exercised once every 36 months for 4 continuous hours. The Executive Director will audit/review the monthly generator set exercise with Director of Plant Operations 1 X per Months X 6 Months Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all staff in service hall.	
E 0004 SS=F 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 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			

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	155495	A. BUILDING -- B. WING	08/29/2022

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	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 review and update the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator, Facility Maintenance Support, and Maintenance Director on 08/29/22 at 10:41 a.m., the EEP from the nurses' station had a review date of 11/01/18. The EPP from the maintenance office had a review date of 04/01/22 but it was determined the book was not properly updated due to most of the information was from a different facility named Lakeland Nursing and did not pertain to Paddock Springs. Based on an interview during records review, the Administrator and Maintenance Director agreed the EPP books were not properly reviewed and updated.	E 0004	**E-004 – Develop EP Plan, Review and Update Annually** Compliance Date – 9/23/22 **Immediate Intervention** The Executive Director has updated the Emergency Operations Plan for both locations – Nurse station and maintenance office. The Executive Director was educated by Facilities Management Support on E004 Develop EP plan, review, and update annually. The facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. The Executive Director will audit	09/23/2022

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	This finding was reviewed with the Administrator, Facility Maintenance Support, and Maintenance Director during the exit conference.		the Emergency preparedness communication 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants.	
E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency			

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

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	not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator, Facility Maintenance Support, and Maintenance Director on 08/29/22 at 10:41 a.m., the EEP Policies and Procedures from the nurses' station had a review date of 11/01/18. Based on an interview during records review, the Administrator and Maintenance Director agreed the EPP Policies and Procedures from the nurses' station has not been reviewed and updated annually. This finding was reviewed with the Administrator, Facility Maintenance Support, and Maintenance Director during the exit conference.	E 0013	**E-013 – Development of EP policies and procedures** Compliance Date – 9/23/22 **Immediate Intervention** The Executive Director has updated the Policies and Procedures to include emergency services in the Emergency Operations Plan for both locations – Nurse station and maintenance office. The Executive Director was educated by Facilities Management Support on E013 Development of EP Policies and Procedures. The LTC facility must develop and implement emergency preparedness and polices 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. The Executive Director will audit the Emergency preparedness communication 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue	09/23/2022

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			until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants.	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator, Facility Maintenance Support, and Maintenance Director on 08/29/22 at 10:41 a.m., the EEP Communication Plan from the nurses' station had a review date of 11/01/18. Based on an interview during records review, the Administrator and	E 0029	**E-029 – Development of Communication Plan** Compliance Date – 9/23/22 **Immediate Intervention** The Executive Director has removed out date policies and updated the Emergency Operations Plan located at the Nurse station. The Executive Director was educated by Facilities Management Support on E029 Develop EP plan, review, and update annually. The facility must	09/23/2022

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	Maintenance Director agreed the EPP Communication Plan from the nurses' station has not been reviewed and updated annually. This finding was reviewed with the Administrator, Facility Maintenance Support, and Maintenance Director during the exit conference.		develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. The Executive Director will audit the Emergency preparedness communication 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants.	
E 0031 SS=C Bldg. --	403.748(c)(2), 416.54(c)(2), 418.113(c)(2), 441.184(c)(2), 482.15(c)(2), 483.475(c)(2), 483.73(c)(2), 484.102(c)(2), 485.625(c)(2), 485.68(c)(2), 485.727(c)(2), 485.920(c)(2), 486.360(c)(2), 491.12(c)(2), 494.62(c)(2) Emergency Officials Contact Information §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(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]. The communication plan must include all of the following: (2) Contact information for the following:			

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	(i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency.			
	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff (ii) The State Licensing and Certification Agency (iii) The Office of the State Long-Term Care Ombudsman (iv) Other sources of assistance in accordance with 42 CFR 483.73(c) (2). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator, Facility Maintenance Support, and Maintenance Director on 08/29/22 at 10:45 a.m., the emergency preparedness communication plan for Federal,	E 0031	**E-031 – Emergency Officials contact Information** Compliance Date – 9/23/22 **Immediate Intervention** The Executive Director has updated the Emergency Operations Plan to include contact information for ombudsman located at all locations. The Executive Director was educated by Facilities Management Support E031, Emergency Officials Contact Information to include Federal, State, Tribal, Regional, and local emergency preparedness staff.	09/23/2022

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	State, Tribal emergency preparedness staff contact information was missing the Office of the State Long-Term Care Ombudsman. Based on interview at the time of record review, the Administrator, Facility Maintenance Support, and Maintenance Director stated the plan was missing the Ombudsman phone number. This finding was reviewed with the Administrator, Facility Maintenance Support, and Maintenance Director during the exit conference.		The State Licensing and Certification Agency. The Office of the State Long-Term Care Ombudsman, Other sources of assistance. The Executive Director will audit the Emergency preparedness officials contact information 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants.	
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			

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	develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):]			

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	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 review and update the Emergency Preparedness Plan (EPP) Training and Testing Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator, Facility Maintenance Support, and Maintenance Director on 08/29/22 at 10:41 a.m., the EEP Training and Testing Plan from the nurses' station had a review date of 11/01/18. Based on an interview during records review, the Administrator and Maintenance Director agreed the EPP Training and Testing Plan from the nurses' station has not been reviewed and updated annually. This finding was reviewed with the Administrator, Facility Maintenance Support, and Maintenance Director during the exit conference.	E 0036	**E-036 – Training and Testing** Compliance Date – 9/23/22 **Immediate Intervention** The Executive Director has updated the Training and Testing plan for the Emergency Operations Plan located at the Nurse station. The Executive Director was educated by Facilities Management Support on E036 Develop EP plan, review, and update annually to include Training and Testing (483.73(d). The facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. The Executive Director will audit the Emergency preparedness training and testing 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team	09/23/2022

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			determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least			

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

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	155495	A. BUILDING -- B. WING	08/29/2022

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	functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion			

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

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

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

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

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

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	*[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency	E 0039	**E-039 -Testing Requirements** Compliance Date – 10/5/22	10/05/2022

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	plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator, Facility Maintenance Support, and Maintenance Director on 08/29/22 at 10:49 a.m., no		**Immediate Intervention** The Executive Director has completed the facilities-based tabletop exercise and has scheduled a community-based exercise to be completed by 10/5/22. The Executive Director was educated by Facilities Management Support on E039 Testing Requirements 483.73(d) The facility must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drill using the emergency procedures. The Executive Director will audit the Emergency preparedness testing requirements 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants	

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	documentation of a community based annual exercise, nor documentation of an additional annual exercise of choice within the last year was available for review. Based on interview at the time of records review, the Administrator and Maintenance Director stated the facility did not participate in a full-scale exercise that is community-based nor an additional exercise within the last 12 months. This finding was reviewed with the Administrator, Facility Maintenance Support, and Maintenance Director 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			

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	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 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.			

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	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. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on records review and interview, the facility failed to implement the emergency power system 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.	E 0041	**E-041– LTC Emergency Power** Compliance Date – 9/23/22 **Immediate Intervention** The Director of Plant Operations conducted a monthly load for the	09/23/2022

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	Findings include: Based on records review with the Administrator and Maintenance Director on 08/29/22 at 10:02 a.m., the generator lacked monthly load testing required by LSC and NFPA 110. Based on interview at the time of record review, the Maintenance Director stated the generator was missing some of the required testing. This finding was reviewed with the Administrator, Facility Maintenance Support, and Maintenance Director during the exit conference.		generator The Executive Director and Director of Plant Operations was educated by the Facilities Management Support on E041 LTC Emergency Power. The LTC Facility must implement the emergency power system inspection, testing, and requirements found in the NFPA 110. The Executive Director will audit the Emergency preparedness LTC emergency power 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants.	
K 0000 Bldg. 02	A Life Safety Code Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/29/22 Facility Number: 000491 Provider Number: 155495 AIM Number: 100291230 At this Life Safety Code survey, Paddock Springs was found not in compliance with Requirements	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to	

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	for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This one story facility constructed in 2018 was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wire smoke detection in the corridors, areas open to the corridors and in all resident rooms. The facility is fully protected by a Type II ESS 150 kW Natural Gas generator. The Healthcare Facility is connected to an Assisted Living Facility (Residential Board and Care Occupancy) from which it is separated by a Fire Wall with a 2-hour Fire Resistance Rating. All areas where the residents will have customary access were sprinklered. The facility has a capacity of 60 and had a census of 54 at the time of this survey. Quality Review completed on 09/08/22		the allegation of noncompliance cited during the survey visit with exit on August 29, 2022. **E-004 – Develop EP Plan, Review and Update Annually** Compliance Date – 9/23/22 **Immediate Intervention** The Executive Director has updated the Emergency Operations Plan for both locations – Nurse station and maintenance office. The Executive Director was educated by Facilities Management Support on E004 Develop EP plan, review, and update annually. The facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. The Executive Director will audit the Emergency preparedness communication 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants. **E-013 – Development of EP policies and procedures** Compliance Date – 9/23/22	

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			Immediate Intervention The Executive Director has updated the Policies and Procedures to include emergency services in the Emergency Operations Plan for both locations – Nurse station and maintenance office. The Executive Director was educated by Facilities Management Support on E013 Development of EP Policies and Procedures. The LTC facility must develop and implement emergency preparedness and polices 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. The Executive Director will audit the Emergency preparedness communication 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants. **E-029 – Development of Communication Plan**	

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			Compliance Date – 9/23/22 **Immediate Intervention** The Executive Director has removed out date policies and updated the Emergency Operations Plan located at the Nurse station. The Executive Director was educated by Facilities Management Support on E029 Develop EP plan, review, and update annually. The facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. The Executive Director will audit the Emergency preparedness communication 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants. **E-031 – Emergency Officials contact Information** Compliance Date – 9/23/22 **Immediate Intervention** The Executive Director has updated the Emergency Operations Plan to include contact information for ombudsman	

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			located at all locations. The Executive Director was educated by Facilities Management Support E031, Emergency Officials Contact Information to include Federal, State, Tribal, Regional, and local emergency preparedness staff. The State Licensing and Certification Agency. The Office of the State Long-Term Care Ombudsman, Other sources of assistance. The Executive Director will audit the Emergency preparedness officials contact information 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants. **E-036 – Training and Testing** Compliance Date – 9/23/22 **Immediate Intervention** The Executive Director has updated the Training and Testing plan for the Emergency Operations Plan located at the Nurse station. The Executive Director was educated by Facilities Management Support on E036 Develop EP plan, review, and	

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			update annually to include Training and Testing (483.73(d). The facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. The Executive Director will audit the Emergency preparedness training and testing 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants. **E-039 -Testing Requirements** Compliance Date – 10/5/22 **Immediate Intervention** The Executive Director has completed the facilities-based tabletop exercise and has scheduled a community-based exercise to be completed by 10/5/22. The Executive Director was educated by Facilities Management Support on E039 Testing Requirements 483.73(d) The facility must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drill using the emergency procedures. The Executive Director will audit	

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			the Emergency preparedness testing requirements 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants. **E-041– LTC Emergency Power** Compliance Date – 9/23/22 **Immediate Intervention** The Director of Plant Operations conducted a monthly load for the generator The Executive Director and Director of Plant Operations was educated by the Facilities Management Support on E041 LTC Emergency Power. The LTC Facility must implement the emergency power system inspection, testing, and requirements found in the NFPA 110. The Executive Director will audit the Emergency preparedness LTC emergency power 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial	

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			compliance has been achieved. This deficient practice had the potential to affect all occupants. **K-131 – Multiple Occupancies** Compliance Date – 9/23/22 **Immediate Intervention** The Director of Plant Operations has acquired the appropriate documentation showing the window in the 90 – minute fire rated door was provided with a fire rated – glazing material. The Director of Plant operations was educated by the Executive Director on K131 Multiple Occupancies, LSC 8.3.3 Section 8.3.3.12 states new fire protection – rated glazing shall be marked in accordance with Table 8.3.3.12 and Table 8.3.4.2, and such marking shall be permanently affixed. The Director of Plant Operations will audit the deficient window located in the 90-minute rated door for appropriate glazing material 1 X per week X 6 weeks. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect 20 residents in one smoke compartment.	

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			K-211 – Means of Egress Compliance Date – 9/19/22 **Immediate Intervention** The Director of Plant Operations removed food serving equipment, two soiled linen carts, boxes, and furniture stored in the Service Hall corridor. The Director of Plant Operations was educated by the Executive Director on K211 – Means of Egress – General. Aisles, passageways, corridor's, exit discharges, exit locations, and access are in accordance with Chapter 7 The Director of Plant Operations will audit the Service Hall corridor for obstructions impeding the path of egress 1 X per week X 6 weeks. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice would affect staff using the Service Hall exit. **K-222 – Egress Doors** Compliance Date – 9/19/22 **Immediate Intervention** The Director of Plant has installed signage indicating that the exit door located on 300 hall could be opened in 15 seconds by pushing on the doors.	

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			The Director of Plant Operations was educated by the Executive Director on K22, Means of Egress, LSC 7.2.1.6.1 (3)(4) states a readily visible, durable sign in letters not less than 1 in. high and not less than 1/8 in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress. “PUSH UNTIL ALARMSOUNDS. DOOR CAN BE OPENED IN 15 SECONDS” The Director of Plant Operations will audit the deficient door on the 300 hall for appropreait signage 1 X per week X 6 weeks X 2 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect 15 residents in the 300 -hall K-324 – Cooking Facilities Compliance Date – 9/19/22 **Immediate Intervention** The Director of Plant Operations and Kitchen staff have clean the kitchen hood removing the oily sludge. The Hood Cleaning Contractor was scheduled for quarterly cleanings of the hood system. The Director of Plant Operations	

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			was educated by the Executive Director on K324, Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial cooking Operations. The Director of Plant Operations will audit the kitchen hood for cleanliness 1 X per day X 4weeks X 1 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect at least 30 residents in the dining room and kitchen staff. **K-341 – Fire Alarm System – Installation** Compliance Date – 9/23/22 **Immediate Intervention** The Director of Plant Operations contacted contractor to move the smoke detector located in the breakroom with a minimum of 36in. from the air supply. The Director of Plant Operations was educated by the Executive Director on K341, Fire Alarm System – installation. A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electrical Code, and	

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			NFPA 72, National Fire Alarm Code. The Director of Plant Operations will audit the smoke detector in the breakroom for location 1 X per week X 4weeks X 1 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect staff in the breakroom. **K-351 – Sprinkler System - Installation.** Compliance Date – 9/23/22 **Immediate Intervention** The Director of Plant Operations has contacted Contractor to have the sprinkler head moved and extended. The Director of Plant Operations was educated by the Executive Director on K351, Sprinkler System – Installation. Buildings are to be protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the installation of sprinkler systems. The Director of Plant Operations will audit the deficient sprinkler head located in dining room for proper installation 1 X per week X 4weeks X 1 months. Results of this audit will be	

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			presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all residents. **K-353 – Sprinkler System – Maintenance and Testing** Compliance Date – 9/23/22 **Immediate Intervention** The Director of Plant Operations has contacted contractor to replace the deficient gauge on the sprinkler system. The Director of Plant Operations was educated by the Executive Director on K353, Sprinkler System – Maintenance and Testing Automatic sprinkler and standpipe systems are inspected tested and maintained in accordance with NFPA 25. The Director of Plant Operations will audit the sprinkler gauge for proper inspection and date 1 X per week X 4weeks X 1 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all residents, staff, and visitors in the facility.	

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			K-363 – Corridor – Doors Compliance Date – 9/19/22 **Immediate Intervention** The Director of Plant Operations removed the door wedge propping the Therapy door open. The Director of Plant Operations was educated by the Executive Director on K363, 18.3.6.3 There is no impediment to the closing of the doors. The Director of Plant Operations will audit Therapy for wedges that could prop door open 1 X per week X 4weeks X 1 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect 6 residents in Therapy gym. **K-372 – Subdivision of Building Spaces – Smoke Barrier Construction** Compliance Date – 9/19/22 **Immediate Intervention** The Director of Plant Operations has made repairs to the two penetrations located 100 hall smoke barriers. The Director of Plant Operations was educated by the Executive Director on K363, NFPA 101,	

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			2012 edition Smoke barriers shall be constructed to provide at least a 1-hour fire resistance rating and constructed in accordance with 8.5 The Director of Plant Operations will audit smoke barrier located on 100 for penetrations 1 X per week X 4weeks X 1 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect 20 residents in two smoke compartments. **K-379 – Smoke Barrier Door Glazing** Compliance Date – 9/23/22 **Immediate Intervention** The Director of Plant Operations has acquired the appropriate documentation showing the window in 5 of 5 smoke barrier doors with windows was provided with a fire rated – glazing material. The Director of Plant Operations was educated by the Executive Director on K379, Smoke Barrier Door Glazing. Windows in smoke barrier doors shall be installed in each cross-corridor swing or horizonal-sliding door protected by fire – rated glazing or by wired glass panels in approved frames.	

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			18.3.7.9 The Director of Plant Operations will audit the 5 of 5 smoke barrier doors for fire rated glazing 1 X per week X 4weeks X 1 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all residents. **K-712 – Fire Drills** Compliance Date – 9/23/22 **Immediate Intervention** The Director of Plant Operations has conducted a fire drill for each shift The Director of Plant Operations was educated by the Executive Director on K712, Fire drills, NFPA 101, Fire Drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The Executive Director will audit/review each fire drill with the Director of Plant Operations 1 X Month X 3 Months Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	

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			This deficient practice could affect all staff and residents. **K-754 – Soiled Linen and Trash Containers** Compliance Date – 9/23/22 **Immediate Intervention** The Director of Plant Operations has removed the two 30-gallon soiled linen carts that are side by side in the service hall corridor. The Director of Plant Operations was educated by the Executive Director on K754, Soiled Linen and Trash Containers, soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The Director of Plant Operations will audit the service hall for the storage of soiled linen carts assuring this does not exceed more than 32 gallons within 64 sq feet 1 X per day X 4weeks X 1 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all staff in service hall. **K-918 – Electrical Systems – Essential Electrical System Maintenance and Testing.** Compliance Date – 9/22/22	

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			Immediate Intervention The Director of Plant Operations has exercised the generator set for a minimum of 30 minutes and documented. The Director of Plant Operations was educated by the Executive Director on K918, NFPA 101 Electrical System Essential Electrical System Maintenance and Testing. Generator sets are inspected weekly, exercised under load 30 minutes 12 times per year in 20–40-day intervals, and exercised once every 36 months for 4 continuous hours. The Executive Director will audit/review the monthly generator set exercise with Director of Plant Operations 1 X per Months X 6 Months Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all staff in service hall.	
K 0131 SS=E Bldg. 02	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing,			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.3, 42 CFR 482.41, 42 CFR 485.623 Based on observation and interview, the facility failed to ensure 1 of 1 90-minute fire rated separation barrier doors with a window met the proper requirements for window glazing in accordance with LSC 8.3.3. Section 8.3.3.12 states new fire protection-rated glazing shall be marked in accordance with Table 8.3.3.12 and Table 8.3.4.2, and such marking shall be permanently affixed. 8.3.3.6 Glazing in fire window assemblies, other than in existing fire window installations of wired glass and other fire-rated glazing material, shall be of a design that has been tested to meet the conditions of acceptance of NFPA 257or ANSI/UL 9. Fire protection-rated glazing in fire door assemblies, other than in existing fire-rated door assemblies, shall be of a design that has been tested to meet the conditions of acceptance of NFPA252, ANSI/UL 10B, or 10C. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation with the Facility	K 0131	**K-131 – Multiple Occupancies** Compliance Date – 9/23/22 **Immediate Intervention** The Director of Plant Operations has acquired the appropriate documentation showing the window in the 90 – minute fire rated door was provided with a fire rated – glazing material. The Director of Plant operations was educated by the Executive Director on K131 Multiple Occupancies, LSC 8.3.3 Section 8.3.3.12 states new fire protection – rated glazing shall be marked in accordance with Table 8.3.3.12 and Table 8.3.4.2, and such marking shall be permanently affixed. The Director of Plant Operations will audit the deficient window located in the 90-minute rated door for appropriate glazing	09/23/2022

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	Maintenance Support, and Maintenance Director on 08/29/22 at 12:40 p.m., the separation fire door was a 90-minute rated fire door with a window. The window lacked an identifier or marking, and it was unknown if the window was provided with a fire-rated glazing material. Based on interview at the time of observation, the Facility Maintenance Support agreed the window was not marked with a fire-rated glazing identifier and stated it was unknown if the glass in the rated door was a fire-rated glazing material. This finding was reviewed with the Administrator, Facility Maintenance Support, and Maintenance Director during the exit conference. 3.1-19(b)		material 1 X per week X 6 weeks. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect 20 residents in one smoke compartment.	
K 0211 SS=E Bldg. 02	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure the means of egress in 1 of 6 corridors were continuously maintained free of obstructions. This deficient practice would affect staff using the Service Hall exit. Findings include: Based on observation with the Facility Maintenance Support and Maintenance Director on 08/29/22 at 12:42 p.m., the Service Hall was not	K 0211	**K-211 – Means of Egress** Compliance Date – 9/19/22 **Immediate Intervention** The Director of Plant Operations removed food serving equipment, two soiled linen carts, boxes, and furniture stored in the Service Hall corridor. The Director of Plant Operations was educated by the Executive	09/19/2022

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	continuously maintained free of obstructions due to food serving equipment, two soiled linen carts, boxes, and furniture stored in the corridor. Based on interview at the time of observation, with the Facility Maintenance Support and Maintenance Director stated the items in the hall will need to be removed from the hall. This finding was reviewed with the Administrator, Facility Maintenance Support, and Maintenance Director during the exit conference. 3.1-19(b)		Director on K211 – Means of Egress – General. Aisles, passageways, corridor's, exit discharges, exit locations, and access are in accordance with Chapter 7 The Director of Plant Operations will audit the Service Hall corridor for obstructions impeding the path of egress 1 X per week X 6 weeks. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice would affect staff using the Service Hall exit.	
K 0222 SS=E Bldg. 02	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,			

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

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	throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 7 delayed egress locks was readily accessible for all residents, staff, and visitors. LSC 7.2.1.6.1.(3)(4) states a readily visible, durable sign in letters not less than 1 in. (25mm) high and not less than 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect 15 residents in the 300-hall. Findings include: Based on observations with the Facility Maintenance Support and Maintenance Director on 08/29/22 at 1:17 p.m., the 300-hall exit door was provided with a delayed egress lock but lacked the proper signage indicating the door could be opened in 15 seconds by pushing on the door. Based on interview at the time of observation, with the Facility Maintenance Support and Maintenance Director stated the delayed egress sign must have fell off the door. This finding was reviewed with the Administrator, Facility Maintenance Support, and Maintenance Director during the exit conference. 3.1-19(b)	K 0222	**K-222 – Egress Doors** Compliance Date – 9/23/22 **Immediate Intervention** The Director of Plant has installed signage indicating that the exit door located on 300 hall could be opened in 15 seconds by pushing on the doors. The Director of Plant Operations was educated by the Executive Director on K22, Means of Egress, LSC 7.2.1.6.1 (3)(4) states a readily visible, durable sign in letters not less than 1 in. high and not less than 1/8 in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress. “PUSH UNTIL ALARMSOUNDS. DOOR CAN BE OPENED IN 15 SECONDS” The Director of Plant Operations will audit the deficient door on the 300 hall for appropreait signage 1 X per week X 6 weeks X 2 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect	09/23/2022

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			15 residents in the 300 -hall	
K 0324 SS=E Bldg. 02	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, records review, and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems were cleaned and inspected in accordance with NFPA 96. Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4 which states systems serving high-volume cooking operations, such as 24-hour cooking, charbroiling, or wok cooking requires quarterly inspections. Section 11.6.1 states, upon inspection, if the exhaust	K 0324	K-324 – Cooking Facilities Compliance Date – 9/19/22 **Immediate Intervention** The Director of Plant Operations and Kitchen staff have clean the kitchen hood removing the oily sludge. The Hood Cleaning Contractor was scheduled for quarterly cleanings of the hood system. The Director of Plant Operations was educated by the Executive	09/19/2022

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	system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. This deficient practice could affect at least 30 residents in the dining room and kitchen staff. Findings include: Based on observation with the Facility Maintenance Support and Maintenance Director on 08/29/22 at 12:40 p.m., under the kitchen hood system there was a charbroil grill and the vents above the grill were completely covered with an oily sludge. Based on records review at 10:00 a.m., the hood system is inspected and cleaned for grease build up semiannually instead of quarterly. Based on interview at the time of observation, the Facility Maintenance Support stated the facility uses the charbroil gill daily to cook hamburgers and hot dogs and there was heavy build up with grease. The Maintenance Director agreed the hood is only inspected for grease and cleaned twice a year. This finding was reviewed with the Administrator, Facility Maintenance Support, and Maintenance Director during the exit conference. 3.1-19(b)		Director on K324, Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial cooking Operations. The Director of Plant Operations will audit the kitchen hood for cleanliness 1 X per day X 4weeks X 1 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect at least 30 residents in the dining room and kitchen staff.	
K 0341 SS=E Bldg. 02	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation			

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	A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was installed in accordance with 18.3.4.1. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 17.7.4.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect staff in the break room. Findings include: Based on observation with the Facility Maintenance Support and Maintenance Director on 08/29/22 at 1:14 p.m., in the staff break room there was a smoke detector next to an air supply where air flow would prevent proper operation of the detector. The detector was about 24 inches from the vent. Based on interview at the time of observation, the Facility Maintenance Support and Maintenance Director agreed the smoke detector was in the direct airflow from air supply and was within 24 inches of the vent.	K 0341	**K-341 – Fire Alarm System – Installation** Compliance Date – 9/23/22 **Immediate Intervention** The Director of Plant Operations contacted contractor to move the smoke detector located in the breakroom with a minimum of 36in. from the air supply. The Director of Plant Operations was educated by the Executive Director on K341, Fire Alarm System – installation. A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code. The Director of Plant Operations will audit the smoke detector in the breakroom for location 1 X per week X 4weeks X 1 months. Results of this audit will be	09/23/2022

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	This finding was reviewed with the Administrator, Facility Maintenance Support, and Maintenance Director during the exit conference. 3.1-19(b)		presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect staff in the breakroom.	
K 0351 SS=E Bldg. 02	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 NEW Buildings are to be 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 and local regulations prohibit sprinklers. Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed six square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 18.3.5.1, 18.3.5.4, 18.3.5.5, 18.3.5.6, 9.7, 9.7.1.1(1), 18.3.5.10 Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 20 sprinkler heads in the dining/community area were not obstructed in accordance with 18.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to	K 0351	**K-351 – Sprinkler System - Installation.** Compliance Date – 9/23/22 **Immediate Intervention** The Director of Plant Operations	09/23/2022

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	discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect all residents. Findings include: Based on observation with the Facility Maintenance Support, and Maintenance Director on 08/29/22 at 12:31 p.m., in the dining/community area by the parlor a sprinkler head was two inches from a ceiling light. This condition would obstruct the spray pattern of the sprinkler. Based on interview at the time of observation, the Facility Maintenance Support agreed the spray pattern of the sprinkler would be obstructed and provide the measurement between the sprinkler and light. This finding was reviewed with the Administrator, Facility Maintenance Support, and Maintenance Director during the exit conference. 3.1-19(b)		has contacted Contractor to have the sprinkler head moved and extended. The Director of Plant Operations was educated by the Executive Director on K351, Sprinkler System – Installation. Buildings are to be protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the installation of sprinkler systems. The Director of Plant Operations will audit the deficient sprinkler head located in dining room for proper installation 1 X per week X 4weeks X 1 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all residents.	
K 0353 SS=C Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a			

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	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 failed to ensure 1 of 8 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations with the Facility Maintenance Support and Maintenance Director on 08/29/22 at 1:11 p.m., the supervised sprinkler systems with eight gauges had one gauge older than five years and was dated 2016. No recalibration date information was affixed to the sprinkler system gauge. Based on interview at the time of the observations, the Maintenance Director agreed one gauge was older than five years.	K 0353	**K-353 – Sprinkler System – Maintenance and Testing** Compliance Date – 9/23/22 **Immediate Intervention** The Director of Plant Operations has contacted contractor to replace the deficient gauge on the sprinkler system. The Director of Plant Operations was educated by the Executive Director on K353, Sprinkler System – Maintenance and Testing Automatic sprinkler and standpipe systems are inspected tested and maintained in accordance with NFPA 25. The Director of Plant Operations will audit the sprinkler gauge for proper inspection and date 1 X per week X 4weeks X 1 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect	09/23/2022

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	This finding was reviewed with the Administrator, Facility Maintenance Support, and Maintenance Director during the exit conference. 3.1-19(b)		all residents, staff, and visitors in the facility.	
K 0363 SS=E Bldg. 02	NFPA 101 Corridor - Doors Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and 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 18.3.6.3.6 are permitted. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of 2 therapy gym corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke.	K 0363	**K-363 – Corridor – Doors** Compliance Date – 9/19/22 **Immediate Intervention** The Director of Plant Operations	09/19/2022

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	This deficient practice could affect 6 residents in the therapy gym. Findings include: Based on observation with the Facility Maintenance Support and Maintenance Director on 08/29/22 at 1:28 p.m., the main corridor door therapy was propped open with a door wedge. Based on interview at the time of observation, the Maintenance Director acknowledged the door was propped open and removed the door wedge. This finding was reviewed with the Administrator, Facility Maintenance Support, and Maintenance Director during the exit conference. 3.1-19(b)		removed the door wedge propping the Therapy door open. The Director of Plant Operations was educated by the Executive Director on K363, 18.3.6.3 There is no impediment to the closing of the doors. The Director of Plant Operations will audit Therapy for wedges that could prop door open 1 X per week X 4weeks X 1 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect 6 residents in Therapy gym.	
K 0372 SS=E Bldg. 02	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 NEW Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3 Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 5	K 0372	**K-372 – Subdivision of Building Spaces – Smoke Barrier Construction**	09/19/2022

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	smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 18.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum 1-hour fire resistive rating. This deficient practice could affect 20 residents in two smoke compartments. Findings include: Based on observation with the Facility Maintenance Support and Maintenance Director on 08/29/22 at 1:31 p.m., above the ceiling tile of the 100 Hall smoke barrier there were two small, unsealed penetrations around wiring. Based on interview at the time of observation, the Maintenance Director acknowledged the unsealed holes in the 100 Hall smoke wall. This finding was reviewed with the Administrator, Facility Maintenance Support, and Maintenance Director during the exit conference. 3.1-19(b)		Compliance Date – 9/19/22 **Immediate Intervention** The Director of Plant Operations has made repairs to the two penetrations located 100 hall smoke barriers. The Director of Plant Operations was educated by the Executive Director on K363, NFPA 101, 2012 edition Smoke barriers shall be constructed to provide at least a 1-hour fire resistance rating and constructed in accordance with 8.5 The Director of Plant Operations will audit smoke barrier located on 100 for penetrations 1 X per week X 4weeks X 1 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect 20 residents in two smoke compartments	
K 0379 SS=F Bldg. 02	NFPA 101 Smoke Barrier Door Glazing Smoke Barrier Door Glazing 2012 NEW Windows in smoke barrier doors shall be installed in each cross corridor swinging or horizontal-sliding door protected by fire-rated glazing or by wired glass panels in approved frames. 18.3.7.9			

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	Based on observation and interview, the facility failed to ensure 5 of 5 smoke barrier doors with windows met the proper requirements for window glazing in accordance with LSC 18.3.7.9 and 18.3.7.10. LSC 18.3.7.9 states vision panels consisting of fire-rated glazing in approved frames shall be provided in each cross-corridor swinging door and at each cross-corridor horizontal-sliding door in a smoke barrier. 18.3.7.10 states vision panels in doors in smoke barriers, if provided, shall be of fire-rated glazing in approved frames. This deficient practice could affect all residents. Findings include: Based on observation with the Facility Maintenance Support, and Maintenance Director on 08/29/22 between 12:00 p.m. and 2:00 p.m., the five smoke barrier doors contained windows that were not marked, and it was unknown if the windows contained a fire-rated glazing material. Based on interview at the time of observation, the Facility Maintenance Support agreed the windows were not marked with fire-rated glazing identifier and stated it was unknown if the glass windows in the smoke doors were provided with a fire-rated glazing material. This finding was reviewed with the Administrator, Facility Maintenance Support, and Maintenance Director during the exit conference. 3.1-19(b)	K 0379	**K-379 – Smoke Barrier Door Glazing** Compliance Date – 9/23/22 **Immediate Intervention** The Director of Plant Operations has acquired the appropriate documentation showing the window in 5 of 5 smoke barrier doors with windows was provided with a fire rated – glazing material. The Director of Plant Operations was educated by the Executive Director on K379, Smoke Barrier Door Glazing. Windows in smoke barrier doors shall be installed in each cross-corridor swing or horizonal-sliding door protected by fire – rated glazing or by wired glass panels in approved frames. 18.3.7.9 The Director of Plant Operations will audit the 5 of 5 smoke barrier doors for fire rated glazing 1 X per week X 4weeks X 1 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all residents.	09/23/2022
K 0712 SS=E Bldg. 02	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire			

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	conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7 Based on record review and interview, the facility failed to conduct fire drills or documented orientation training on for 2 of 4 quarters. QSO-20-31 1135 temporary waiver from starting 03/20/20 and ending on 06/07/22 states in lieu of a physical fire drill, a documented orientation training program related to the current fire plan, which considers current facility conditions, is acceptable. The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area. This deficient practice affects all staff and residents. Findings include: Based on record review with the Administrator, Facility Maintenance Support, and Maintenance Director on 08/29/22 at 10:31 a.m., the following shifts were missing documentation of a completed fire drill or documented orientation training: a) Third shift drill in the first quarter of 2022. b) Second shift drill in the second quarter of 2021. Based on interview at the time of record review, the Maintenance Director agreed there were missing fire drills and staff has not been trained in the fire safety procedures for the first and seconds quarters.	K 0712	**K-712 – Fire Drills** Compliance Date – 9/23/22 **Immediate Intervention** The Director of Plant Operations has conducted a fire drill for each shift The Director of Plant Operations was educated by the Executive Director on K712, Fire drills, NFPA 101, Fire Drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The Executive Director will audit/review each fire drill with the Director of Plant Operations 1 X Month X 3 Months Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all staff and residents	09/23/2022

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	This finding was reviewed with the Administrator, Facility Maintenance Support, and Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)			
K 0754 SS=E Bldg. 02	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 receptacles in 1 of 6 corridors were maintained in accordance with 18.7.5.7. This deficient practice could affect staff in the service hall. Findings include: Based on observations during a tour of the facility with the Facility Maintenance Support and Maintenance Director on 08/29/22 at 1:01 p.m.,	K 0754	**K-754 – Soiled Linen and Trash Containers** Compliance Date – 9/23/22 **Immediate Intervention** The Director of Plant Operations has removed the two 30-gallon soiled linen carts that are side by side in the service hall corridor. The Director of Plant Operations was educated by the Executive	09/23/2022

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	there were two 30-gallon soiled linen carts side by side in the service hall corridor. Based on interview at the time of observation, the Maintenance Director stated there were two 30-gallon carts of soiled linen totaling 60 gallons in a 64 square foot area in the service hall corridor. This finding was reviewed with the Administrator, Facility Maintenance Support, and Maintenance Director during the exit conference. 3.1-19(b)		Director on K754, Soiled Linen and Trash Containers, soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The Director of Plant Operations will audit the service hall for the storage of soiled linen carts assuring this does not exceed more than 32 gallons within 64 sq feet 1 X per day X 4weeks X 1 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all staff in service hall	
K 0918 SS=F Bldg. 02	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours.			

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	Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1 Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 7 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include:	K 0918	**K-918 – Electrical Systems – Essential Electrical System Maintenance and Testing.** Compliance Date – 9/22/22 **Immediate Intervention** The Director of Plant Operations has exercised the generator set for a minimum of 30 minutes and documented. The Director of Plant Operations was educated by the Executive Director on K918, NFPA 101 Electrical System Essential Electrical System Maintenance and Testing. Generator sets are inspected weekly, exercised under load 30 minutes 12 times per year in 20–40-day intervals, and exercised once every 36 months	09/22/2022

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	Based on records review with the Administrator, Facility Maintenance Support, and Maintenance Director on 08/29/22 at 11:11 a.m., no documentation was available to show the generator set in service was exercised at least once monthly for a minimum of 30 minutes, for the months of January to July of 2022. Based on an interview at the time of record review, the Maintenance Director stated the monthly load testes were not recorded for 2022. 2. Based on observation and interview, the facility failed to ensure 2 of 2 emergency task generator battery backup lights were maintained. NFPA 110, 2010 Edition at section 7.3.1 requires the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Administrator, Facility Maintenance Support, and Maintenance Director on 08/29/22 at 11:11 a.m., no documentation was available to show the emergency battery powered lights at the generator		for 4 continuous hours. The Executive Director will audit/review the monthly generator set exercise with Director of Plant Operations 1 X per Months X 6 Months Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all staff in service hall.	

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	and transfer switch were tested monthly for a minimum of 30 seconds. Based on an interview at the time of record review, the Maintenance Director stated the monthly light tests for the lights at the generator were not tested in 2022. . This finding was reviewed with the Administrator, Facility Maintenance Support, and Maintenance Director during the exit conference. 3.1-19(b)			