STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155661	A. BUILDING -- B. WING	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OWEN VALLEY REHABILITATION AND HEALTHCARE CENTER	920 W HIGHWAY 46 SPENCER, IN 47460

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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: 12/16/24 Facility Number: 010892 Provider Number: 155661 AIM Number: 200229560 At this Emergency Preparedness survey, Owen Valley Rehabilitation And Healthcare Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 113 certified beds, with a current census of 76. Quality Review completed on 12/23/24 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	This plan of correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied. The facility respectfully requests a desk review and consideration of paper compliance for this plan of correction.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). 1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator	E 0041	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified as being affected by the alleged deficient practice.	01/27/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael Meadows	Executive Director	01/06/2025

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

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	was provided with a properly operating alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' stations. NFPA 99, 2012 Edition, Health Care Facilities Code, at 6.4.1.1.17 requires a remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate: a. When the emergency or auxiliary power source is operating to supply power to load. b. When the battery charger is malfunctioning. (2) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: a. Low lubricating oil pressure. b. Low water temperature. c. Excessive water temperature. d. Low fuel when the main fuel storage tank contains less than a 4-hour operating supply. e. Overcrank (failed to start). f. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 6.4.1.1.17(1) and (2) occur but need not display these conditions individually. This deficient practice could affect all residents, as well as visitors and staff in the facility. Findings include: Based on observation on 12/16/24 between 2:30 p.m. and 5:00 p.m. during a tour of the facility with		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. (1) Evapar, an outside contractor that installed the new generator was contacted to install an annunciator panel that meets the requirement. Maintenance Director will routinely inspect annunciator panel for proper operation during scheduled generator test. (2) Maintenance Director will complete a written record of monthly generator load testing as required. (3) Maintenance Director will complete and document weekly inspections and testing of the emergency generator. (4) On December 17, 2024, the Maintenance Director verified that there was a battery-operated light inside the generator housing located near the battery. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. (1) The Maintenance Director will routinely inspect annunciator panel for proper operation during	

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	the Executive Director, Regional Director of Operations, and Maintenance Director from a sister facility, there was a remote generator annunciator panel located on the wall in the sitting area across from the west Nurse's Station area. When tested by pushing all of the buttons, the generator annunciator panel did not operate. Based on interview at the time of observation, the Regional Director of Operations said the facility had a new generator installed within the past two months and was told by the vendor that the existing equipment, i.e., transfer switch and annunciator panel, would be compatible with the new generator. The Regional Director of Operations then called the vendor and scheduled an appointment to correct the issue with the generator annunciator panel not currently operating. This finding was reviewed with the Executive Director, Regional Director of Operations, and Maintenance Director from the sister facility during the exit conference. 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 4 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.		scheduled generator test. (2) Maintenance Director will complete and record the results of monthly generator load testing as required. (3) Maintenance Director will complete and record the results of weekly inspections and testing of the emergency generator. (4) The Maintenance Director will routinely verify that a battery-operated light is located inside the generator housing near the battery. How the corrective actions will be monitored to ensure the deficient practice does not recur. (1) Maintenance Director or designee will audit the annunciator panel for proper operation weekly X 4 weeks with any issues reported at morning meeting, then monthly X 5 months with any issues reported at the monthly QAPI meeting. (2) Executive Director or designee will audit documentation of the written record of monthly generator load testing monthly for 6 months. Results will be reviewed at the monthly QAPI meeting. (3) Executive Director will audit weekly inspections and testing of the emergency generator weekly X 4 weeks and then monthly X 5 months. Results will be reviewed at the monthly QAPI meeting.	

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	Findings include: Based on record review on 12/16/24 between 10:00 a.m. and 2:30 p.m. with the Executive Director, Regional Director of Operations, and Maintenance Director from a sister facility present, the following was noted: a. There was no monthly generator load test documentation available for May, June, July, and August of 2024 for the emergency generator. Based on interview at the time of record review, the Executive Director confirmed there was no monthly load test documentation available for August and September of 2024. Based on interview at the time of record review, the Regional Director of Operations said the facility had a temporary generator during most of that time frame and the vendor of the temporary generator was supposed to perform the monthly load tests/inspections. The Regional Director of Operations was unable to produce monthly load tests/inspections of the generator either from the vendor or in house maintenance logs. b. The monthly load testing reports that were available for review were dated 01/03/24, 02/21/24, 03/22/24, 04/30/24, 10/14/24, 11/12/24, and 12/10/24, all had percentage of load as 30% or 36%. None of those monthly reports had the calculations included as to how the facility reached the 30% or 36% mark. Only one monthly generator load test report was provided with the calculations, and that report was dated 09/10/24 at 42%. This was confirmed by the Regional Director of Operations at the time of record review. This finding was reviewed with the Executive Director, Regional Director of Operations, and Maintenance Director from the sister facility during the exit conference.		(4) Maintenance Director or designee will verify and document that a battery-operated light is stored within the generator weekly X 4 weeks and then monthly X 5 months. Any discrepancy will be corrected immediately and reported at the morning meeting. Results will be discussed at the monthly QAPI meeting.	

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	3. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 1 generator was maintained for 31 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection and testing reports on 12/16/24 between 10:00 a.m. and 2:30 p.m. with the Executive Director, Regional Director of Operations, and Maintenance Director from a sister facility present, there was no documentation available to show the emergency generator was inspected/tested weekly between 02/21/24 to 10/01/24. Based on interview at the time of record review, the Regional Director of Operations said the facility had a temporary generator during most of that time frame and the vendor of the temporary generator was supposed to perform the weekly inspections. The Regional Director of Operations was unable to produce weekly inspections of the generator either from			

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	the vendor or in house maintenance logs. This finding was reviewed with the Executive Director, Regional Director of Operations, and Maintenance Director from the sister facility during the exit conference. 4. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator was provided with a battery backup light. 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 observation on 12/16/24 between 2:30 p.m. and 5:00 p.m. during a tour of the facility with the Executive Director, Regional Director of Operations, and Maintenance Director from a sister facility, the emergency generator was located at the rear of the facility at least 100 feet from the nearest parking lot. There was no battery back up light set provided in or around the generator. Based on an interview at the time of observation, the Maintenance Director from the			

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	sister facility acknowledged there was no battery back up light set in or around the emergency generator. This finding was reviewed with the Executive Director, Regional Director of Operations, and Maintenance Director from the sister facility during the exit conference.			
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/16/24 Facility Number: 010892 Provider Number: 155661 AIM Number: 200229560 At this Life Safety Code survey, Owen Valley Rehabilitation And Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 113 and had a census of 76 at the time of this survey.	K 0000	This plan of correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied. The facility respectfully requests a desk review and consideration of paper compliance for this plan of correction.	

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	All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 12/23/24			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as a storage room door, was provided with a self closing device. This deficient practice could at least 20 residents and staff. Findings include: Based on observations on 12/16/24 between 2:30 p.m. and 5:00 p.m. during a tour of the facility with the Executive Director, Regional Director of Operations, and Maintenance Director from a sister facility, the PPE storage room corridor door was locked, however, it was not provided with a self closing device. The room was over 50 square feet in size and stored over 50 cardboard boxes full of PPE supplies and other combustible items. Based on interview at the time of observation, the Executive Director acknowledged the PPE storage room was not provided with a self closing device. This finding was reviewed with the Executive Director, Regional Director of Operations, and Maintenance Director from the sister facility during the exit conference. 3.1-19(b)	K 0321	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified as being affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. On December 23, 2024, the Maintenance Director installed a self closing hinge on the door to the identified storage room. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The Maintenance Director or	01/06/2025

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			designee will ensure that all storage areas have a self closing door during weekly safety rounds. Any discrepancies will be corrected immediately and reported at the morning meeting. How the corrective actions will be monitored to ensure the deficient practice does not recur. The Maintenance Director or designee will inspect storage spaces for a self closing door weekly X 4 weeks and then monthly X 5 months with any issues reported at the monthly QAPI meeting.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices	K 0345	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified as being affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to	01/27/2025

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	This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 12/16/24 between 10:00 a.m. and 2:30 p.m. with the Executive Director, Regional Director of Operations, and Maintenance Director from a sister facility present, there was documentation provided regarding an annual fire alarm system inspection dated 12/26/23 by the facility's fire alarm inspection vendor. This inspection listed 112 hard wired smoke detector and 8 duct smoke detectors as having been tested/inspected visually and functionally. Furthermore, there was a "Semi-Annual Visual Inspections Fire Systems" report dated 06/10/24 conducted by the facility's Maintenance Director. This report only listed 73 hard wired smoke detectors and 7 duct smoke detectors as being visually inspected. Based on interview at the time of record review, the Executive Director agreed semi-annual visual inspection report did not match the annual inspection report's number of hard wired smoke detectors and duct smoke detectors. This finding was reviewed with the Executive Director, Regional Director of Operations, and Maintenance Director from the sister facility during the exit conference. 3.1-19(b)		be affected. The Maintenance Director has created a list of all hard wired smoke and duct detectors that includes their location. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The Maintenance Director has created and will maintain a list of all hard wired smoke and duct detectors that includes their location. This list will be updated as needed and used for any required testing. How the corrective actions will be monitored to ensure the deficient practice does not recur. The Maintenance Director will audit the hard wired smoke and duct detector list monthly X 6 months to verify that it is accurate, and no changes are needed. Any discrepancies will be corrected immediately. Results will be reviewed at the monthly QAPI meeting.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to ensure only one type of sprinkler head,	K 0351	What corrective action(s) will be accomplished for those residents	01/27/2025

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	i.e. quick response or standard sprinklers were installed in 1 of 8 smoke compartments. NFPA 13, 2010 Edition, Installation of Sprinkler Systems, Section 8.3.3.2 states where quick-response sprinklers are installed, all sprinklers within a compartment shall be quick-response unless otherwise permitted in Section 8.3.3.3 Section 8.3.3.4 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a compartmented space shall be changed. This deficient practice could affect at least 10 residents, staff, and visitors. Findings include: Based on observations on 12/16/24 between 2:30 p.m. and 5:00 p.m. during a tour of the facility with Executive Director, Regional Director of Operations, and Maintenance Director from the sister, in the egress corridor near the east exit door and outside the laundry room door there was one standard response sprinkler head mixed with all other quick response sprinkler heads. Based on interview at the time of observation, this was acknowledged by the Executive Director who agreed there was a mixture of different type sprinkler heads in this compartmented spaces. This finding was reviewed with the Executive Director, Regional Director of Operations, and Maintenance Director from the sister facility during the exit conference. 3.1-19(b)		found to have been affected by the deficient practice: No residents were identified as being affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. All deficient sprinkler heads that were identified during the inspection will be replaced by a qualified contractor. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. All sprinkler heads will be inspected routinely by the Maintenance Director or designee to ensure all sprinkler heads are the same response type. How the corrective actions will be monitored to ensure the deficient practice does not recur. The Maintenance Director or designee is to complete inspection and auditing of affected	

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			sprinkler heads weekly X 4 weeks and then monthly X 5 months to ensure sprinkler heads are of the same response type. These results will be reviewed and discussed at the monthly QAPI meeting.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 dry sprinkler system during 38 of the past 52 weeks for the sprinkler system's pressure gauges, and during 8 of the past 12 months for the sprinkler system's control valves. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: a. Based on record review on 12/16/24 between	K 0353	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified as being affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. 1a. The Maintenance Director or designee will inspect the dry sprinkler system gauges weekly. 1b. The Maintenance Director or designee will inspect the sprinkler system control valves monthly. 2. All deficient sprinkler heads that were identified during the inspection will be replaced by a qualified contractor. 3. Backup sprinkler heads that	01/27/2025

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OWEN VALLEY REHABILITATION AND HEALTHCARE CENTER	920 W HIGHWAY 46 SPENCER, IN 47460

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	10:00 a.m. and 2:30 p.m. with the Executive Director, Regional Director of Operations, and Maintenance Director from a sister facility present, there was no documentation available to show the facility's dry sprinkler system gauges were inspected weekly during 38 of the past 52 week period. The only weekly sprinkler gauge inspections available for review were from 09/10/24 to 12/09/24. Based on interview at the time of record review, the Regional Director of Operations confirmed there was no documentation available to show that the facility's sprinkler gauges had been inspected at least weekly during 38 of the past 52 weeks. Based on observations on 12/16/24 between 2:30 p.m. and 5:00 p.m. during a tour of the facility with the Executive Director, Regional Director of Operations, and Maintenance Director from the sister facility, the facility had four pressure gauges at the sprinkler riser. b. Based on record review on 12/16/24 between 10:00 a.m. and 2:30 p.m. with the Executive Director, Regional Director of Operations, and Maintenance Director from a sister facility present, there was no monthly sprinkler system control valves inspection documentation for 8 of the past 12 months. The only monthly inspections available were for September, October, November, and December of 2024. Based on interview at the time of record review, the Regional Director of Operations confirmed the lack of sprinkler system inspections on the control valves during 8 the past 12 months. This finding was reviewed with the Executive Director, Regional Director of Operations, and Maintenance Director from the sister facility during the exit conference.		were not needed in the spare sprinkler box were removed and sprinkler heads of the same type and temperature as the facility were added to meet the requirement. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1a. The Maintenance Director or designee will complete and record the results of the weekly dry sprinkler system gauges inspection. 1b. The Maintenance Director or designee will complete and record the results of the monthly sprinkler system control valve inspection. 2. All sprinkler heads will be inspected routinely by the Maintenance Director or designee to ensure they are free of corrosion. 3. The Maintenance Director or designee will routinely inspect the spare sprinkler head box to ensure that it has the correct spare sprinkler heads that match the type and temperature of those in the facility. How the corrective actions will be monitored to ensure the deficient practice does not recur.	

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure a sprinkler head in 1 of 8 smoke compartments covered with corrosion was replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect mostly laundry staff, plus residents and visitors while in the same smoke compartment. Findings include: Based on observations on 12/16/24 between 2:30 p.m. and 5:00 p.m. during a tour of the facility with the Executive Director, Regional Director of Operations, and Maintenance Director from a sister facility, there was one sprinkler head in the washer area within the laundry room covered with corrosion. Based on interview at the time of observation, the Executive Director agreed the sprinkler head was covered with corrosion and should be replaced. This finding was reviewed with the Executive Director, Regional Director of Operations, and Maintenance Director from the sister facility during the exit conference. 3.1-19(b)		1a. The Executive Director will audit the results of the weekly dry sprinkler system gauges inspection weekly X 4 weeks and then monthly X 5 months. 1b. The Executive Director will audit the monthly sprinkler system control valve inspection monthly X 6 months. 2. The Maintenance Director or designee is to complete inspection and auditing of affected sprinkler heads weekly X 4 weeks and then monthly X 5 months. These results will be reviewed and discussed at the monthly QAPI meeting. 3. The Maintenance Director will audit the spare sprinkler head box to ensure that it has spare sprinkler heads that match the same type and temperature as the facility weekly X 4 weeks and then monthly X 5 months.	

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	3. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with the minimum number of spare sprinklers in a spare sprinkler cabinet on the premises for the types and temperature ratings of the sprinklers on the property. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations on 12/16/24 between 2:30 p.m. and 5:00 p.m. during a tour of the facility with the Executive Director, Regional Director of Operations, and Maintenance Director from a sister facility, Pendent type Quick Response sprinkler heads were installed throughout the facility, except for the attic. There were no pendent type Quick Response spare sprinkler heads within the spare sprinkler cabinet at the sprinkler system riser or on the premises. Based on interview at the time of the observations, the Executive Director agreed the spare sprinkler cabinet did not contain any pendent type Quick Response spare sprinkler heads.			

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	This finding was reviewed with the Executive Director, Regional Director of Operations, and Maintenance Director from the sister facility during the exit conference. 3.1-19(b)			
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Based on record review and interview, the facility failed to provide a complete facility specific written fire safety plan for the protection of all residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use	K 0711	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified as being affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. a. The facility emergency procedure plan has been changed to identify smoke barrier locations and evacuation procedure in detail. b. The facility emergency procedure plan has been changed to clarify when the K type extinguisher would be used in relationship to the overhead extinguishing system.	01/27/2025

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	ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the facility's Emergency Procedure-Fire plan on 12/10/24 between 10:00 a.m. and 3:00 p.m. with the Executive Director, Regional Director of Operations, and Maintenance Director from a sister facility present, the plan did not address the following: a. The plan did address evacuation of the smoke compartment, however, the plan did not identify where the smoke barriers were located in the facility and evacuation in detail. b. The use of the K-class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead extinguishing system. However, the plan did say "Note: Kitchen fire extinguishers are Type K." Based on interview at the time of record review, the Executive Director acknowledged the Emergency Procedure-Fire plan did not include the previously mentioned items. This finding was reviewed with the Executive Director, Regional Director of Operations, and Maintenance Director from the sister facility during the exit conference. 3.1-19(b)		What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. a. The facility emergency procedure plan is more detailed to help identify smoke barrier locations and the evacuation procedure in more detail. b. The facility emergency procedure plan provides more detail as to when the K type extinguisher would be used in relationship to the overhead extinguishing system. How the corrective actions will be monitored to ensure the deficient practice does not recur. a. The Executive Director or designee will audit the emergency procedure plan to ensure that it identifies smoke barrier locations and the evacuation procedure in more detail monthly X 6 months. The result will be reviewed in the monthly QAPI meeting. b. The Executive Director or designee will audit the emergency procedure plan to ensure that it provides clarification as to when the K type extinguisher would be used in relationship to the overhead extinguishing system monthly X 6 months. The result will be reviewed in the monthly QAPI meeting.	

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K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 3 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 12/16/24 between 10:00 a.m. and 2:30 p.m. with the Executive Director, Regional Director of Operations, and Maintenance Director from a sister facility present, 3 of 4 second shift (evening) fire drills were performed between 6:16 p.m. and 7:30 p.m. Based on interview at the time of record review, the Executive Director acknowledged the times the second shift fire drills were performed and agreed the times were not varied enough. This finding was reviewed with the Executive Director, Regional Director of Operations, and Maintenance Director from the sister facility during the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified as being affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. The Maintenance Director will schedule fire drills to be held on unexpected days at unexpected times under varying conditions. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The Maintenance Director or designee will monitor the fire drill schedule to ensure that fire drills are held on unexpected days at unexpected times under varying conditions.	01/27/2025

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			How the corrective actions will be monitored to ensure the deficient practice does not recur. The Executive Director or designee will audit fire drills monthly X 6 months to ensure fire drills are held on unexpected days at unexpected times and under varying conditions with any issues reported at the monthly QAPI meeting.	
K 0916 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator was provided with a properly operating alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' stations. NFPA 99, 2012 Edition, Health Care Facilities Code, at 6.4.1.1.17 requires a remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate: a. When the emergency or auxiliary power source is operating to supply power to load. b. When the battery charger is malfunctioning. (2) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: a. Low lubricating oil pressure. b. Low water temperature. c. Excessive water temperature.	K 0916	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified as being affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. Evapar, an outside contractor that installed the new generator was contacted to install an annunciator panel that meets the requirement. Maintenance Director will routinely inspect annunciator panel for proper	01/27/2025

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	d. Low fuel when the main fuel storage tank contains less than a 4-hour operating supply. e. Overcrank (failed to start). f. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 6.4.1.1.17(1) and (2) occur but need not display these conditions individually. This deficient practice could affect all residents, as well as visitors and staff in the facility. Findings include: Based on observation on 12/16/24 between 2:30 p.m. and 5:00 p.m. during a tour of the facility with the Executive Director, Regional Director of Operations, and Maintenance Director from a sister facility, there was a remote generator annunciator panel located on the wall in the sitting area across from the west Nurse's Station area. When tested by pushing all of the buttons, the generator annunciator panel did not operate. Based on interview at the time of observation, the Regional Director of Operations said the facility had a new generator installed within the past two months and was told by the vendor that the existing equipment, i.e., transfer switch and annunciator panel, would be compatible with the new generator. The Regional Director of Operations then called the vendor and scheduled an appointment to correct the issue with the generator annunciator panel not currently operating. This finding was reviewed with the Executive Director, Regional Director of Operations, and Maintenance Director from the sister facility		operation during scheduled generator test. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The Maintenance Director will routinely inspect annunciator panel for proper operation during scheduled generator test. How the corrective actions will be monitored to ensure the deficient practice does not recur. Maintenance Director or designee will audit the annunciator panel for proper operation weekly X 4 weeks with any issues reported at morning meeting, then monthly X 5 months with any issues reported at the monthly QAPI meeting.	

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	during the exit conference. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste 1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 4 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 12/16/24 between 10:00 a.m. and 2:30 p.m. with the Executive Director, Regional Director of Operations, and Maintenance Director from a sister facility present, the following was noted: a. There was no monthly generator load test documentation available for May, June, July, and August of 2024 for the emergency generator. Based on interview at the time of record review, the Executive Director confirmed there was no monthly load test documentation available for August and September of 2024. Based on interview at the time of record review, the Regional Director of Operations said the facility had a temporary generator during most of that	K 0918	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified as being affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. (1) Maintenance Director will complete a written record of monthly generator load testing as required. (2) Maintenance Director will complete and document weekly inspections and testing of the emergency generator. (3) On December 17, 2024, the Maintenance Director verified that there was a battery-operated light inside the generator housing located near the battery.	01/27/2025

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	time frame and the vendor of the temporary generator was supposed to perform the monthly load tests/inspections. The Regional Director of Operations was unable to produce monthly load tests/inspections of the generator either from the vendor or in house maintenance logs. b. The monthly load testing reports that were available for review were dated 01/03/24, 02/21/24, 03/22/24, 04/30/24, 10/14/24, 11/12/24, and 12/10/24, all had percentage of load as 30% or 36%. None of those monthly reports had the calculations included as to how the facility reached the 30% or 36% mark. Only one monthly generator load test report was provided with the calculations, and that report was dated 09/10/24 at 42%. This was confirmed by the Regional Director of Operations at the time of record review. This finding was reviewed with the Executive Director, Regional Director of Operations, and Maintenance Director from the sister facility during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 1 generator was maintained for 31 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of		What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. (1) Maintenance Director will complete and record the results of monthly generator load testing as required. (2) Maintenance Director will complete and record the results of weekly inspections and testing of the emergency generator. (3) The Maintenance Director will routinely verify that a battery-operated light is located inside the generator housing near the battery. How the corrective actions will be monitored to ensure the deficient practice does not recur. (1) Executive Director or designee will audit documentation of the written record of monthly generator load testing monthly for 6 months. Results will be reviewed at the monthly QAPI meeting. (2) Executive Director will audit weekly inspections and testing of the emergency generator weekly X 4 weeks and then monthly X 5 months. Results will be reviewed at the monthly QAPI meeting. (3) Maintenance Director or designee will verify and document that a battery-operated light is stored within the generator weekly	

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	defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection and testing reports on 12/16/24 between 10:00 a.m. and 2:30 p.m. with the Executive Director, Regional Director of Operations, and Maintenance Director from a sister facility present, there was no documentation available to show the emergency generator was inspected/tested weekly between 02/21/24 to 10/01/24. Based on interview at the time of record review, the Regional Director of Operations said the facility had a temporary generator during most of that time frame and the vendor of the temporary generator was supposed to perform the weekly inspections. The Regional Director of Operations was unable to produce weekly inspections of the generator either from the vendor or in house maintenance logs. This finding was reviewed with the Executive Director, Regional Director of Operations, and Maintenance Director from the sister facility during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator was provided with a battery backup light. 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		X 4 weeks and then monthly X 5 months. Any discrepancy will be corrected immediately and reported at the morning meeting. Results will be discussed at the monthly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155661	A. BUILDING 01 B. WING	12/16/2024

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	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 observation on 12/16/24 between 2:30 p.m. and 5:00 p.m. during a tour of the facility with the Executive Director, Regional Director of Operations, and Maintenance Director from a sister facility, the emergency generator was located at the rear of the facility at least 100 feet from the nearest parking lot. There was no battery back up light set provided in or around the generator. Based on an interview at the time of observation, the Maintenance Director from the sister facility acknowledged there was no battery back up light set in or around the emergency generator. This finding was reviewed with the Executive Director, Regional Director of Operations, and Maintenance Director from the sister facility during the exit conference. 3.1-19(b)			
K 0921 SS=F	NFPA 101 Electrical Equipment - Testing and			

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Bldg. 01	Maintenanc Based on record review, observation, and interview; the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice could affect all residents. Findings include: Based on record review on 12/16/24 between 10:00 a.m. and 2:30 p.m. with the Executive Director, Regional Director of Operations, and Maintenance Director from a sister facility present, there was no documentation for the testing of PCREE, such as	K 0921	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified as being affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. The Maintenance Director or designee will inspect all Patient Care Related Electrical Equipment. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The Maintenance Director or designee will complete and record the results of all Patient Care Related Electrical Equipment inspections. How the corrective actions will be monitored to ensure the deficient practice does not recur.	01/27/2025

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	electric beds, nebulizers, oxygen concentrators, air pumps for air mattresses, vital sign monitors, and other electrical medical equipment. Based on interview at the time of record review, the Regional Director of Operations said the facility was not aware PCREE items had to be tested and documented. Based on observation between 2:30 p.m. to 5:00 p.m. during a tour of the facility with the Executive Director, Regional Director of Operations, and Maintenance Director from the sister facility , it was revealed the facility provided PCREE such as electric beds, nebulizers, oxygen concentrators, air pumps for air mattresses, vital sign monitors, and other electrical medical equipment was present in the facility. This finding was reviewed with the Executive Director, Regional Director of Operations, and Maintenance Director from the sister facility during the exit conference. 3.1-19(b)		The Executive Director will audit the results of all Patient Care Related Electrical Equipment inspections weekly X 4 weeks and then monthly X 5 months with any issues reported at the monthly QAPI meeting.	