STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155427	A. BUILDING -- B. WING	10/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT MADISON	1945 CRAGMONT ST MADISON, IN 47250

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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: 10/17/22 Facility Number: 000348 Provider Number: 155427 AIM Number: 100288390 At this Emergency Preparedness survey, Hickory Creek at Madison was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 36 certified beds. At the time of the survey, the census was 33. Quality Review completed on 10/21/22 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.** **Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit.**	
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.			

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

Markietta L Burns | Executive Director | 11/07/2022

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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	The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 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			

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	Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 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.			

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	(xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review, observation and interview; the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the visiting Maintenance Director and the Housekeeping Supervisor from 10:00 a.m. to 12:10 p.m. on 10/17/22, thirty-six month period emergency generator testing documentation for four continuous hours for the facility's emergency generator was not available for review. Based on interview at the time of record review, the visiting Maintenance Director stated the facility has one LP gas fired emergency generator and agreed documentation of available load testing for four hours within the most recent three year period was not available for review. Based on observations with the visiting Maintenance Director and the Housekeeping Supervisor during a tour of the facility from 12:10 p.m. to 1:10 p.m. on 10/17/22, the facility has one LP gas fired emergency generator located outside the building. Manufacturer's nameplate rating for the generator stated it was rated at 25 kW. This finding was reviewed with the visiting Maintenance Director and the Housekeeping Supervisor during the exit conference.	E 0041	It is the practice of this facility to ensure that a 4hr emergency generator test is completed every three years in accordance with the regulations. A 4hr emergency generator test has been completed and updated into the Emergency Operations Plan. **The corrective action taken for those residents found to be affected by the deficient practice include:** A 4hr emergency generator test has been completed and updated into the Emergency Operations Plan **Other residents that have the potential to be affected have been identified by:** All residents, staff and visitors have the potential to be affected but none were identified. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur:** Maintenance Director has been in-serviced on emergency generator testing in accordance with the regulations. Maintenance Director will review his monthly PM to ensure testing is completed when the next test is due. **The corrective action taken to monitor performance to assure**	11/04/2022

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			compliance through quality assurance is: TELS has been updated to include a 3 yr. 4 hour generator testing for LP gas fired emergency generator. Next testing due 2025. The Emergency Operations Plan has been updated. **Date of Completion: November 4th, 2022**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/17/22 Facility Number: 000348 Provider Number: 155427 AIM Number: 100288390 At this Life Safety Code survey, Hickory Creek at Madison 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 II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and has battery powered smoke detectors in all resident sleeping rooms.	K 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.** **Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit.**	

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	The facility has a capacity of 36 and had a census of 33 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility storage were sprinklered except for two detached buildings which were not sprinklered. Quality Review completed on 10/21/22			
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 1 of 1 therapy rooms was separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Therapy Services room. Findings include:	K 0361	It is the practice of this facility to ensure that areas open to corridor spaces meet all applicable regulations. The door prop was removed from the therapy door. **The corrective action taken for those residents found to be affected by the deficient practice include:** The door prop was removed from the therapy door. **Other residents that have the potential to be affected have been identified by:** All other doors have been inspected for door props, none were identified. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not**	11/04/2022

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	Based on observations with the visiting Maintenance Director and the Housekeeping Supervisor during a tour of the facility from 12:10 p.m. to 1:10 p.m. on 10/17/22, the corridor door to the Therapy Services room was propped in the fully open position with a sand filled therapy device placed on the floor up against the door. Based on interview at the time of the observations, the visiting Maintenance Director and the Housekeeping Supervisor agreed the corridor door to the Therapy Services room was propped in the fully open position. This finding was reviewed with the visiting Maintenance Director and the Housekeeping Supervisor during the exit conference. 3.1-19(b)		**recur:** All staff have been in-serviced on keeping corridors clear without obstruction (including door props) for required exits. Maintenance Director will inspect doors for props monthly during his PM rounds. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** The Executive Director will round with the maintenance director prior to the compliance date to ensure all doors are free from door props. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks were completed. **Date of Completion: November 4th, 2022**	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by			

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	CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of over 20 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the kitchen. Findings include: Based on observations with the visiting Maintenance Director and the Housekeeping	K 0363	It is the practice of this facility to ensure that corridor doors have no impediment to closing and latching into the door frame. Wedge removed from door. **The corrective action taken for those residents found to be affected by the deficient practice include:** Wedge removed from door. Mag lock repaired. **Other residents that have the**	11/04/2022

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	Supervisor during a tour of the facility from 12:10 p.m. to 1:10 p.m. on 10/17/22, the corridor door to the kitchen was propped in the nearly fully open position with a wedge placed on the floor under the door. A magnetic door holding device was in place on the floor to hold the door in the fully open position but was not energized. Based on interview at the time of the observations, the visiting Maintenance Director and the Housekeeping Supervisor agreed the corridor door to the kitchen had an impediment to closing and latching into the door frame and would not resist the passage of smoke. This finding was reviewed with the visiting Maintenance Director and the Housekeeping Supervisor during the exit conference. 3.1-19(b)		**potential to be affected have been identified by:** All other doors were inspected for wedges, none were identified. All mag locks reviewed for proper function and no issues noted. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur:** Maintenance Director was in-serviced regarding the importance of ensuring corridors remaining free from impediments and ensuring magnetic door holding device is fully operational. Maintenance Director will inspect all doors monthly during his PM rounds to ensure no wedges are being used and magnetic door holding devices are fully operational. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** The Executive Director will round with the maintenance director prior to the compliance date to ensure door wedges are not being used and all mag locks are functional. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks were completed. **Date of Completion: November 4th, 2022**	

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K 0372 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.			
	Based on observation and interview, the facility failed to ensure 1 of 1 smoke barrier walls were protected to maintain the fire resistance of the smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the visiting Maintenance Director and the Housekeeping Supervisor during a tour of the facility from 12:10 p.m. to 1:10 p.m. on 10/17/22, the annular space surrounding a one inch in diameter red water line which penetrated the smoke barrier wall above the suspended ceiling above the corridor door set by Room 4 was not firestopped and was not protected to maintain the fire resistance of the smoke barrier. Based on interview at the time of the observations, the visiting Maintenance Director agreed the aforementioned opening in the	K 0372	It is the practice of this facility to ensure that all smoke barrier walls are protected to maintain the fire resistance of the smoke barrier. Annular space has been fixed with fire caulk. **The corrective action taken for those residents found to be affected by the deficient practice include:** Annular space has been fixed with fire caulk. **Other residents that have the potential to be affected have been identified by:** All smoke barriers were inspected for holes, no other concerns were identified. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur:** Maintenance Director in-serviced on smoke barriers in accordance with life safety	11/04/2022

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	smoke barrier wall was not firestopped. This finding was reviewed with the visiting Maintenance Director and the Housekeeping Supervisor during the exit conference. 3.1-19(b)		regulations. The Maintenance Director will inspect all smoke barriers monthly during his PM round to ensure all smoke barriers are sealed properly. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** The Executive Director will round with the maintenance director prior to the compliance date to ensure all smoke barrier are sealed properly. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks were completed. **Date of Completion: November 4th, 2022**	
K 0761 SS=F Bldg. 01	Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in	K 0761	It is the practice of this facility to ensure maintenance, inspection and testing of fire door assemblies annually in accordance with the regulations. **The corrective action taken for those residents found to be affected by the deficient practice include:** Oxygen storage and transfilling room door was inspected and tested. **Other residents that have the potential to be affected have been identified by:** All doors	11/04/2022

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	accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, Section 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.		were inspected and tested, no other concerns noted **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur:** Maintenance Director has been in-serviced on annual testing and inspection of fire door assemblies. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** The Executive Director will round with the maintenance director prior to the compliance date to ensure all fire door assemblies have been tested and function properly. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks were completed. **Date of Completion: November 4th, 2022**	

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	155427	A. BUILDING 01 B. WING	10/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT MADISON	1945 CRAGMONT ST MADISON, IN 47250

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	(10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS "Fire-Smoke Doors (Opening Protectives): Annual Fire/Smoke Door Inspections" documentation dated 08/22/22 with the visiting Maintenance Director and the Housekeeping Supervisor during record review from 10:00 a.m. to 12:10 p.m. on 10/17/22, annual inspection documentation of fire door assemblies in the facility within the most recent twelve month period did not include doors to the oxygen storage and transfilling room. Based on observations with the visiting Maintenance Director and the Housekeeping Supervisor during a tour of the facility from 12:10 p.m. to 1:10 p.m. on 10/17/22, the corridor door to the oxygen storage and transfilling room by Room 16 was a fire-rated door with a 1-hour fire resistance rating label affixed to the hinge side of the door. Three liquid oxygen containers and one 'E' type oxygen cylinder were stored in the room. Based on interview at the time of the observations, the visiting Maintenance Director provided Direct Supply TELS "Doors, Locks, Gates & Alarms: Hazardous Area Doors" documentation which listed an "Oxygen Storage (internal)" inspection was done on 10/12/22. Based on interview at the time of the exit conference, the visiting Maintenance Director stated the hazardous area doors in the facility are inspected monthly but the tasks for the inspections were not listed in TELS documentation or could not be found in TELS by			

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	the time of the exit conference. This finding was reviewed with the visiting Maintenance Director and the Housekeeping Supervisor during the exit conference. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable,			

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	and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review, observation and interview; the facility failed to document 36 month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the visiting Maintenance Director and the Housekeeping Supervisor from 10:00 a.m. to 12:10 p.m. on 10/17/22, thirty-six month period emergency generator testing documentation for four continuous hours for the facility's emergency generator was not available for review. Based on	K 0918	It is the practice of this facility to ensure that a 4hr emergency generator test is completed every three years in accordance with the regulations. A 4hr emergency generator test has been completed and updated into the Emergency Operations Plan. **The corrective action taken for those residents found to be affected by the deficient practice include:** A 4hr emergency generator test has been completed and updated into the Emergency Operations Plan **Other residents that have the potential to be affected have been identified by:** All residents, staff and visitors have the potential to be affected but none were identified. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur:** Maintenance Director has been in-serviced on emergency generator testing in accordance with the regulations. Maintenance Director will review his monthly PM to ensure testing is completed when the next test is due. **The corrective action taken to monitor performance to assure**	11/04/2022

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	interview at the time of record review, the visiting Maintenance Director stated the facility has one LP gas fired emergency generator and agreed documentation of available load testing for four hours within the most recent three year period was not available for review. Based on observations with the visiting Maintenance Director and the Housekeeping Supervisor during a tour of the facility from 12:10 p.m. to 1:10 p.m. on 10/17/22,the facility has one LP gas fired emergency generator located outside the building. Manufacturer's nameplate rating for the generator stated it was rated at 25 kW. This finding was reviewed with the visiting Maintenance Director and the Housekeeping Supervisor during the exit conference. 3.1-19(b)		**compliance through quality assurance is:** TELS has been updated to include a 3 yr. 4 hour generator testing for LP gas fired emergency generator. Next testing due 2025. The Emergency Operations Plan has been updated. **Date of Completion: November 4th, 2022**	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.			

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	Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure a minimum distance of at least five feet separated combustible materials from oxygen storage equipment in 1 of 1 oxygen storage areas. NFPA 99, Section 11.3.2.3 requires oxidizing gases such as oxygen shall be separated from combustibles by one of the following: (1) a minimum distance of 20 feet. (2) a minimum distance of 5 feet if the required storage location is protected by an automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. This deficient practice could affect all residents,	K 0923	It is the practice of this facility to ensure that gas equipment is contained and stored according to regulation. All oxygen storage has been moved to an outside storage shed. **The corrective action taken for those residents found to be affected by the deficient practice include:** All oxygen storage has been moved to an outside storage shed. **Other residents that have the potential to be affected have been identified by:** There are no other oxygen storage areas in the	11/04/2022

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	staff and visitors. Findings include: Based on observations with the visiting Maintenance Director and the Housekeeping Supervisor during a tour of the facility from 12:10 p.m. to 1:10 p.m. on 10/17/22, a wood enclosure surrounding capped water lines near the floor of the oxygen storage and transfilling room by Room 16 was noted. The wood was painted brown. The top portion of the wood enclosure was detached from the rest of the enclosure which exposed the unpainted interior portion of the enclosure. The wood enclosure was within five feet of three liquid oxygen containers and one 'E' type oxygen cylinder which were stored in the room. Based on interview at the time of the observations, the visiting Maintenance Director stated he did not know if the brown paint was fire retardant and agreed the exposed wood enclosure in the room was less than five feet from the liquid oxygen containers in the room. This finding was reviewed with the visiting Maintenance Director and the Housekeeping Supervisor during the exit conference. 3.1-19(b)		facility. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur:** Maintenance Director has been in-serviced on storage of oxygen and that combustible materials must be at least 5 feet away from oxygen storage. The maintenance director will inspect the oxygen storage area to ensure no combustible items are within 5 feet during his monthly PM rounds. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** The Executive Director will round with the maintenance director prior to the compliance date to ensure all combustible items are at least 5 feet away from oxygen storage. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks were completed. **Date of Completion: November 4th, 2022**	