STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155253	A. BUILDING -- B. WING	10/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MEADOWOOD HEALTH PAVILION	2455 TAMARACK TRAIL BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/15/19 Facility Number: 000156 Provider Number: 155253 AIM Number: 300024459 At this Emergency Preparedness survey, Meadowood Health Pavilion was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 66 certified beds and had a census of 49 at the time of this visit. Quality Review completed on 10/18/19	E 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective November 14th, 2019 to the annual licensure survey conducted on October 15th, 2019. **We respectfully request a paper review. We will provide you with any additional information to confirm compliance per your request.**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/15/19 Facility Number: 000156 Provider Number: 155253 AIM Number: 300024459 At this Life Safety Code survey, Meadowood	K 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective	

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

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	Health Pavilion was found not in compliance with Requirements for Participation in Medicare, 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 smoke detection in the corridor and all areas open to the corridor, plus battery powered smoke alarms in all resident sleeping rooms. The facility has a capacity of 66 and had a census of 49 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 10/18/19		November 14th, 2019 to the annual licensure survey conducted on October 15th, 2019. **We respectfully request a paper review. We will provide you with any additional information to confirm compliance per your request.**	
K 0100 SS=F Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, observation and interview; the facility failed to provide complete documentation for the preventative maintenance of 47 of 47 battery powered smoke alarms in resident rooms. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained.	K 0100	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these	11/14/2019

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	This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 10/15/19 between 9:15 a.m. and 12:15 p.m. with the Maintenance Director present, the facility was able to provide documentation of a preventative maintenance (PM) program for the testing of all battery powered smoke alarms, however, the documentation showed that the battery powered smoke alarms were only tested on a semi annual basis. The most recent two inspections/tests were in February and August of 2019. Based on interview at the time of record review, the Maintenance Director said he was not aware that all battery powered smoke alarms were required to be tested on a monthly basis. Based on observations between 12:15 p.m. and 2:15 p.m. during a tour of the facility with the Maintenance Director, all resident sleeping rooms were equipped with battery powered smoke alarms. 3.1-19(b)		responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective November 14th, 2019 to the annual licensure survey conducted on October 15th, 2019. **We respectfully request a paper review. We will provide you with any additional information to confirm compliance per your request.** **K100 General Requirements** **It is the practice of this facility to maintain existing life safety features obvious to the public specifically, Preventative Maintenance of battery powered smoke alarms.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** 1. Teachable Moment was conducted with Maintenance Director on Preventative Maintenance for battery powered smoke alarms in resident rooms. 2. Maintenance performed testing of battery powered smoke alarms. ***Other residents that have the potential to be affected have been identified by:*** Residents had the potential to be affected. None were identified. ***The measures or systematic changes that have been put into***	

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			place to ensure that the deficient practice does not recur include: Maintenance Staff has been in-serviced on Preventative Maintenance and documentation of battery powered smoke alarms, in resident rooms. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly observes battery powered smoke detector testing and documentation in resident rooms. The Director of Maintenance or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any issues observed out of compliance, re-education will be initiated. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. ***The date the systemic changes will be completed: November 14th, 2019***	
K 0131 SS=F Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or			

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	more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623			
	1. Based on observation and interview, the facility failed to maintain the two-hour rated construction of 1 of 1 fire occupancy separation wall. LSC 8.3.5.1 states Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through- Penetration Firestops, at a minimum positive pressure differential of 0.01 in. water column (2.5 N/m2) between the exposed and the unexposed surface of the test assembly. 8.3.5.2 states where the penetrating item uses a sleeve to penetrate the wall or floor, the sleeve shall be securely set in the wall or floor, and the space between the item and the sleeve shall be filled with a material that	K 0131	**K131 Multiple Occupancies** **It is the practice of this facility to maintain the two-hour rated construction of fire occupancy separation walls without penetrations and it is also the practice of this facility to ensure that the 90 minute rated fire doors close and latch properly.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** 1.Teachable Moments conducted for Maintenance Director for unsealed penetrations where electrical conduit penetrated the two hour fire wall and fire doors not closing and latching appropriately. 2.Penetrations separating the skilled unit from the IL unit Sealed.	11/14/2019

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	complies with 8.3.5.1. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on observation on 10/15/19 at 1:25 p.m. during a tour of the facility with the with the Maintenance Director, the two hour fire wall separating the skilled unit from the assisted living unit had at least five unsealed penetrations ranging in size from two inches to one and a half feet where electrical conduits penetrated the two hour fire wall. Based on interview at the time of observation, the Maintenance Director agreed there were unsealed penetrations in the fire wall that separated the skilled unit from the assisted living and said he was unaware the unsealed penetrations existed. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 2 sets of fire doors in a 2 hour separation wall between the skilled unit and the assisted living unit was maintained. LSC 8.3.3.1 states openings required to have a fire protection rating of 1 1/2 hour in a 2 hour fire wall or partition 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 accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives. 8.3.3.2.2 states all products required shall bear an approved label. This deficient practice could affect all residents, as well as staff and visitors. Findings include:		3.Fire Door Closures between Maintenance service hall on skilled side and the IL kitchen side, adjusted to close and latch properly. ***Other residents that have the potential to be affected have been identified by:*** Residents had the potential to be affected. None were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Maintenance Staff has been in-serviced on maintaining fire occupancy separation walls without penetrations and on Fire doors closing and latching properly. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews 5 separation walls for penetrations and 5 sets of fire doors for proper closure and latching. The Maintenance Director, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as	

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	Based on observation on 10/15/19 at 1:36 p.m. during a tour of the facility with the Maintenance Director, the set of 90 minute rated fire doors between the maintenance service hall on the skilled unit side and the kitchen service hall on the assisted living unit side did not close completely and latch when tested several times. There was a one half inch gap between the doors when closed fully. Based on interview at the time of observation, the Maintenance Director agreed the set of 90 minute fire doors did not close and latch when tested several times and said he didn't know the doors were not closing fully. 3.1-19(b)		needed based on review of the outcomes of the PI tool. ***The date the systemic changes will be completed: November 14, 2019***	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler			

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	Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous areas was separated from the egress corridor. This deficient practice could affect mostly staff and visitors while in the service corridor. Findings include: Based on observation on 10/15/19 at 1:40 p.m. during a tour of the facility with the Maintenance Director, there were at least 15 plastic totes filled with fall and Halloween decorations along with other loose items stored in the service corridor. Based on interview at the time of observation, the Maintenance Director agreed the totes and other items should not be stored in the service corridor and said they would be removed as soon as possible. 3.1-19(b)	K 0321	**K321 Hazardous Areas** **It is the practice of this facility to ensure that hazardous areas are separated from the egress corridor.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** 1.Teachable Moments conducted for Maintenance Director and Activities Director for storing of supplies/tubs in service corridor. ***Other residents that have the potential to be affected have been identified by:*** Staff & Visitors had the potential to be affected. None were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Maintenance & Activity Staff have been in-serviced on proper storage of tubs and decoration supplies	11/14/2019

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			and keeping egress corridors clear. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews service corridor is clean and clear of storage items. The Maintenance Director, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tool. ***The date the systemic changes will be completed: November 14, 2019***	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72			

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	Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 10/15/19 between 9:15 a.m. and 12:15 p.m. with the Maintenance Director present, no documentation could be provided regarding a visual semi-annual fire alarm system inspection. Based on interview at the time of record review, the Maintenance Director said that visual inspections of the fire-alarm system's devices were not performed on a semi annual basis. 3.1-19(b)	K 0345	**K345 Fire Alarm System-Testing & Maintenance** **It is the practice of this facility to maintain the fire alarm systems devices by visual semi-annual fire alarm system inspection.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** 1.Teachable Moment was conducted with Maintenance Director over inspection of fire alarm system devices being completed on a semi-annual basis. 2.Visual Fire Alarm System devices Inspection completed. ***Other residents that have the potential to be affected have been identified by:*** Residents had the potential to be affected. None were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Maintenance Staff has been in-serviced on maintaining fire alarm system devices by making sure systems are inspected on a semi-annual basis. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly	11/14/2019

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			reviews Fire alarm system inspection reports. The Maintenance Director, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tool. ***The date the systemic changes will be completed: November 14, 2019***	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			

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	1. Based on record review, observation and interview; the facility failed to provide complete documentation sprinkler system inspections were in accordance with NFPA 25 for 1 of 1 dry sprinkler system, and 1 of 1 wet system. 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 5.2.4.1 states gauges on wet sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is 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: Based on record review on 10/15/19 between 9:15 a.m. and 12:15 p.m. with the Maintenance Director present, there was documentation available quarterly sprinkler inspections were performed on 01/25/19, 04/10/19, 06/21/19 and 09/03/19. Weekly dry sprinkler system gauge inspection documentation for 48 of the most recent 52 week period was not available for review for the dry sprinkler system. Furthermore, monthly wet sprinkler system gauge inspection documentation for 8 of the most recent 12 month period was also	K 0353	**K353 Sprinkler Systems-Maintenance & Testing** **It is the practice of this facility to ensure that automatic sprinkler and standpipe systems are inspected, tested and maintained.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** 1.Teachable Moment conducted with Maintenance Director regarding 1.Weekly inspections of dry sprinkler system gauges. 2.Monthly inspections of wet sprinkler system gauges. 3.Monthly inspections of sprinkler system control valves. 1.Teachable Moment conducted with Maintenance Director regarding replacement of sprinkler heads with corrosion. Ie Hskg closet and Spa. 2.Teachable Moment conducted with Maintenance Director regarding Holes through ceiling in wheelchair storage had penetrations not properly fire stopped and missing ceiling tiles in Maintenance Directors office. 3.Dry Sprinkler system gauges, wet sprinkler system gauges and Sprinkler system control valves were inspected. 4.Sprinkler heads in Housekeeping closet and spa were replaced. 5.Penetrations in wheelchair	11/14/2019

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	not available for review for the wet sprinkler system. In addition, monthly inspection documentation for the sprinkler system control valves for 8 months of the most recent 12 month period was also not available for review. Based on interview at the time of record review, the Maintenance Director indicated the facility performs regular visual sprinkler system inspections but does not have sprinkler system gauge and control valve inspection documentation for the past 12 months available for review. Based on observations with the Maintenance Director during a tour of the facility from 12:15 p.m. to 2:15 p.m. the facility had a total of 5 gauges between the two sprinkler risers. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of over 500 sprinkler heads in the facility were free of corrosion. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at 5.2.1.1.1 requires sprinklers to be free of paint and corrosion. 5.2.1.1.2 requires any sprinkler that shows signs of paint or corrosion shall be replaced. This deficient practice could affect one resident and staff. Findings include: Based on observations on 10/15/19 between 12:15 p.m. and 2:15 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. There was one sprinkler head in the Housekeeping closet covered with green corrosion. b. There was one sprinkler head in the SPA covered with green corrosion.		storage were properly filled. 6.Ceiling tiles in Maintenance office replaced. ***Other residents that have the potential to be affected have been identified by:*** Residents had the potential to be affected. None were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Maintenance Staff has been in-serviced on maintaining Weekly inspections of dry sprinkler system gauges, Monthly inspections of wet sprinkler system gauges, Monthly inspections of sprinkler system control valves. Maintenance Staff has been in-service regarding replacing sprinkler heads with corrosion, properly fire stopping penetrations in fire walls and replacing missing ceiling tiles. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews documentation of dry sprinkler system gauges weekly inspections, wet sprinkler system gauges monthly inspections and sprinkler system control valves monthly inspections, sprinkler head inspections and replacement, and missing ceiling	

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	Based on interview at the time of each observation, the Maintenance Director agreed the sprinkler heads were covered with green corrosion. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure the ceiling in 2 of 8 sprinklered smoke compartments was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect over 10 residents, as well as staff and visitors. Findings include: Based on observations on 10/15/19 between 12:15 p.m. and 2:15 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. There were four holes through the ceiling within the wheelchair storage closet across from rooms 42 and 43 that ranged in size from one half inch to one inch around conduit penetrations that were not properly fire stopped. b. There were two missing ceiling tiles in the Maintenance Director's office. This was acknowledged by the Maintenance Director at the time of each observation. 3.1-19(b)		tiles. The Maintenance Director, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tool. ***The date the systemic changes will be completed: November 14, 2019***	
K 0511 SS=F Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in			

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	service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure 1 of over 10 wet locations was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI	K 0511	**K511 Utilities** **It is the practice of this facility to ensure that ground fault circuit interrupters for protection against electric shock, are provided to wet locations, switch covers and ceiling tiles are present and in good repair and Electric panels in facility corridors are locked.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** 1.Teachable Moment was conducted with Maintenance Director over electric receptacle with no GFCI protection in soiled utility, replacing missing light switch covers, and keeping electrical panels in corridors locked. 2.GFCI protection added to receptacle in soiled utility. 3.Switch cover placed on double light switch in soiled utility. 4.Electric Panels in Corridor locked. ***Other residents that have the potential to be affected have been identified by:*** Residents had the potential to be affected. None were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:***	11/14/2019

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	protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect one or two staff. Findings include: Based on observation on 10/15/19 at 12:56 p.m. during a tour of the facility with the Maintenance Director, the Soiled Utility Room had one electric receptacles on the wall within two feet of the hopper sink that was not provided with GFCI protection. This was confirmed when the receptacle was tested with a GFCI testing device. This was acknowledged by the Maintenance Director at the time of observation.		Maintenance Staff has been in-serviced on GFCI protection specifically in wet locations, replacing missing light switch covers, and keeping electrical panels in corridors locked. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews light switch covers on and in good repair, GFCI protection on receptacles when appropriate, and fire panels in facility corridors are locked. The Maintenance Director, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tool. ***The date the systemic changes will be completed: November 14, 2019***	

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure a light switch in 1 of 8 smoke compartments was protected. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect one or two staff. Findings include: Based on observation on 10/15/19 at 12:57 p.m. during a tour of the facility with the Maintenance Director, the double light switch cover was missing in the Soiled Utility Room. Based on interview at the time of observation, the Maintenance Director acknowledged the cover was missing on the double light switch in the Soiled Utility Room and said he would put a new cover on as soon as possible. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 10 of 10 electrical panels observed in the corridors were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a			

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	means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on an observations on 10/15/19 between 12:15 p.m. and 2:15 p.m. during a tour of the facility with the Maintenance Director, ten electrical panels in the facility's corridors were unlocked when tested. The panels included breakers to a variety of items in the facility. Based on interview at the time of each observation, the Maintenance Director agreed the electrical panels in the corridors need to be locked and said he would lock them but keys have to be made first for the locks that are currently on the panel. 3.1-19(b)			
K 0761 SS=F Bldg. 01	Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 2 of 2 sets of 90 minute fire rated door assemblies within a two hour fire separation wall, and one oxygen transfilling room door were completed in accordance with 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,	K 0761	**K761 Maintenance/Inspection & Testing- Doors** **It is the practice of this facility to ensure that Fire Doors assemblies are inspected and tested annually.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** 1.Teachable Moment was conducted with Maintenance Director to ensure that Fire Door Assemblies are inspected annually. 2.Fire Door Assemblies	11/14/2019

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	and sills in 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, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 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. (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.		Inspected. ***Other residents that have the potential to be affected have been identified by:*** Residents had the potential to be affected. None were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Maintenance Staff has been in-serviced on annual inspection of fire door assemblies. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews Fire Door Assemblies inspections for annual compliance. The Maintenance Director, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tool. ***The date the systemic changes will be completed: November 14, 2019***	

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	This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on record review on 10/15/19 between 9:15 a.m. and 12:15 p.m. with the Maintenance Director present, the facility was unable to provide documentation for an annual fire door assembly inspection, including two sets of 90 minute fire rated separation door assemblies within a two hour fire separation wall, and the oxygen transfilling room door assembly. Based on interview at the time of record review, the Maintenance Director said the facility does do a regular fire door inspection through their computer based program, but it is only a pass or fail result and not a detailed inspection report that is produced. Based on observations during a tour of the facility with the Maintenance Director between 12:15 p.m. and 2:15 p.m., there were two sets of 90 minute fire rated separation door assemblies within a two hour fire separation wall, and the oxygen transfilling room fire door assembly. Furthermore, the set of 90 minute rated fire doors between the maintenance service hall on the skilled unit side and the kitchen service hall on the assisted living unit side did not close completely and latch when tested several times. There was a one half inch gap between the doors when closed fully. 3.1-19(b)			
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed			

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	locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)			
	Based on observation, record review and interview; the facility failed to ensure all nonhospital-grade electrical receptacles in 47 of 47 resident room locations were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding	K 0914	**K914 Electrical Systems Maintenance & Testing** **It is the practice of this facility to ensure that non hospital grade electrical receptacles in resident room locations are tested annually.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** 1.Teachable Moment conducted for Maintenance Director over annual testing and documentation of testing on non-hospital grade electrical receptacles in resident room locations. 2.47 resident room electrical	11/14/2019

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	blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on record review on 10/15/19 between 9:15 a.m. and 12:15 p.m. with the Maintenance Director present, there was no record of an annual test for each resident room electrical receptacle that was not a hospital-grade receptacle. Based on interview at the time of record review, the Maintenance Director said all of the electrical receptacles in resident rooms were not hospital-grade receptacles as far as he knew. He further said there was no record or documentation to show that annual testing per NFPA 99, Receptacle Testing requirements was met. Based on observations between 12:15 p.m. and 2:15 p.m. during a tour of the facility with the Maintenance Director, there were at least four to six electrical receptacles in each of the resident rooms. 3.1-19(b)		receptacles were tested and documentation completed. ***Other residents that have the potential to be affected have been identified by:*** Residents had the potential to be affected. None were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Maintenance Staff has been in-serviced on proper testing and documentation of non- hospital grade electrical receptacles in resident room locations. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews Annual non hospital grade electrical receptacles in resident room locations. The Maintenance Director, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tool. ***The date the systemic changes will be completed: November 14, 2019***	

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K 0918 SS=C 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, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the facility failed to ensure an annual fuel quality test was	K 0918	**K918 Electrical Systems-Essential Electric Syste**	11/14/2019

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	performed for 1 of 1 diesel powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on record review on 10/15/19 between 9:15 a.m. and 12:15 p.m. with the Maintenance Director present, no documentation of an annual fuel quality test for the diesel generator was available for review. Based on interview at the time of records review, the Maintenance Director stated the facility does have a diesel generator but was unaware of the fuel quality testing requirements. 3.1-19(b)		**It is the practice of this facility to ensure that Annual Fuel quality testing is performed for diesel powered generators.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** 1.Teachable Moments conducted for Maintenance Director for Annual testing and documentation of fuel quality for the diesel generator. 2. Safe Care Contacted for completion of Fuel Quality Testing for diesel generator. ***Other residents that have the potential to be affected have been identified by:*** Residents had the potential to be affected. None were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Maintenance Staff has been in-serviced on proper Annual Testing and documentation of fuel quality for diesel generators. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews annual testing and documentation of fuel quality testing for the diesel generator. The Maintenance Director, or	

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	155253	A. BUILDING 01 B. WING	10/15/2019

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			designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tool. ***The date the systemic changes will be completed: November 14, 2019***	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was			

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	installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure power strips were not used as a substitute for fixed wiring in two staff areas. LSC 19.5.1.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect at least 2 staff. Findings include: Based on observations on 10/15/19 between 12:15 p.m. and 2:15 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. There was a microwave oven, small refrigerator, and a coffee maker plugged into a power strip in the Assistant DON office b. There was a small refrigerator plugged into a power strip in the Administrator's office. Based on interview at the time of each observation, the Maintenance Director acknowledged the use of the power strips in the Assistant DON office and Administrator's office and said he was not aware the power strips were being used. 3.1-19(b)	K 0920	***K 920 Electrical Equipment-Power Cords and Extens*** **It is the practice of this facility to ensure that power strips are not used as a substitute for fixed wiring.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** 1.Teachable Moments conducted for Maintenance Director, Administrator and ADON for use of power strips in offices. 2.Power Strips Removed 10/16/19. ***Other residents that have the potential to be affected have been identified by:*** Residents had the potential to be affected. None were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Maintenance Staff and Administrative staff have been in-serviced on not using power strips as a substitute for fixed wiring. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool	11/14/2019

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			has been initiated that randomly reviews Offices for use of power strips. The Maintenance Director, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tool. ***The date the systemic changes will be completed: November 14, 2019***	
K 0923 SS=D 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. Less than or equal to 300 cubic feet In a single smoke compartment, individual			

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	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 1 of 1 cylinder of nonflammable gases such as a helium tank was properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff in the Activity office. Findings include: Based on observation on 10/15/19 at 1:20 p.m.	K 0923	***923 Gas Equipment-Cylinder and Container Storage*** **It is the practice of this facility to ensure that cylinders of non-flammable gases such as helium tanks are properly secured.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** 1.Teachable Moments conducted for Maintenance Director and Activity Staff for helium tank not being properly supported or secured from falling. . 2.Helium Tank Secured, chain re-attached.	11/14/2019

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	during a tour of the facility with the Maintenance Director, there was one large helium tank on the floor in the Activity office which was not properly supported or secured from falling. Based on interview at the time of observation, the Maintenance Director acknowledged that the helium tank was not secured properly to prevent the cylinder from falling. 3.1-19(b)		***Other residents that have the potential to be affected have been identified by:*** Residents had the potential to be affected. None were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** 1.In-service conducted for Maintenance Director and Activity Staff for helium tank not being properly supported or secured from falling. . ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews Offices for proper storage of Helium tank. The Maintenance Director, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tool. ***The date the systemic changes will be completed: November 14, 2019***	