STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155671	A. BUILDING -- B. WING	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OAKWOOD HEALTH CAMPUS	1143 23RD ST TELL CITY, IN 47586

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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: 04/26/23 Facility Number: 002512 Provider Number: 155671 AIM Number: 200278620 At this Emergency Preparedness survey, Oakwood Health Campus was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 98 certified beds and had a census of 75 at the time of this visit. Quality Review completed on 05/04/23	E 0000	The submission of this plan of correction does not indicate an admission by Oakwood Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Oakwood Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
E 0041 SS=C 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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mary C. Blocker	Executive Director	05/19/2023

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

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	procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety 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.			

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	*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. 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			

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	11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: Based on record review on 04/26/23 between 8:45 a.m. and 11:45 a.m. with the Director of Plant	E 0041	**K 222 Egress Doors** *This Requirement is not met as evidenced by the facility failed to ensure the means of egress through all delayed egress locks was readily accessible for all residents, staff, and visitors. No signage was available that states "Push until alarm sounds. Door can be opened in 15 seconds.* **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** ·The Director of Plant Operations was educated on 5/16/2023 by the Executive Director on NFPA 101-2012 edition sections; 19.2.2.2, 7.2.1.5.10, and 7.2.1.6. ·The Director of Plant Operations has contacted the vendor to repair the service hall door across from the courtyard door on 5/19/2023 to arrange repairs.	06/09/2023

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	Operations and Director of Plant Operations from a sister facility present, the facility provided documentation for a four hour test of the emergency generator on 04/05/23, however, the documentation provided did not include the calculation for the percentage of load during the four hour load test. This was confirmed by the facility's Director of Plant Operations at the time of record review. This finding was reviewed with both Director's of Plant Operations during the exit conference.		**2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** ·No residents were affected, but all have the potential to be affected. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** **·DPO or designee will complete weekly rounds to ensure proper functioning of the door.** **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** ·DPO or designee will complete weekly rounds times 4 weeks. Then every other week weeks 4 weeks. Then monthly. ·For quality assurance, the DPO or designee will review any findings and subsequent corrective action quarterly for at least six months in the campus quality assurance meetings (QAPI). Any identified issues will be reviewed in detail by the QAPI committee and new processes put in place to ensure compliance with this	

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			regulation.	
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: 04/26/23 Facility Number: 002512 Provider Number: 155671 AIM Number: 200278690 At this Life Safety Code survey, Oakwood Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 98 and had a census of 75 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 05/04/23	K 0000	The submission of this plan of correction does not indicate an admission by Oakwood Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Oakwood Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	

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K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS			

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	Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure 1 of 12 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall	K 0222	**K 222 Egress Doors** *This Requirement is not met as evidenced by the facility failed to ensure the means of egress through all delayed egress locks was readily accessible for all residents, staff, and visitors. No signage was available that states "Push until alarm sounds. Door can be opened in 15 seconds.* **1: What corrective action(s) will be accomplished for those residents found to have**	06/09/2023

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	activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect mostly staff, plus any residents, as well as staff and visitors while in the service hall. Findings include: Based on observations on 04/26/23 between 11:45 a.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operations and Director of Plant Operations from a sister facility, the Service Hall exit door across from the courtyard door was equipped with delayed egress. When the panic bar on the door was pushed for 15 seconds several times the door did not release from the magnetic hold located at the top of the door. However, the magnetic hold did release the door when the code was pushed on the keypad located next to the door. Based on interview at the time of observation, the facility's Director of Plant Operations said this door was just worked on within the past week by the fire alarm system inspection vendor, but must not have been fixed properly. This finding was reviewed with both Director's of Plant Operations during the exit conference. 3.1-19(b)		**affected by the deficient practice?** ·The Director of Plant Operations was educated on 5/16/2023 by the Executive Director on NFPA 101-2012 edition sections; 19.2.2.2, 7.2.1.5.10, and 7.2.1.6. ·The Director of Plant Operations has contacted the vendor to repair the service hall door across from the courtyard door on 5/19/2023 to arrange repairs. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** ·No residents were affected, but all have the potential to be affected. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** **·DPO or designee will complete weekly rounds to ensure proper functioning of the door.** **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?**	

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			·DPO or designee will complete weekly rounds times 4 weeks. Then every other week weeks 4 weeks. Then monthly. ·For quality assurance, the DPO or designee will review any findings and subsequent corrective action quarterly for at least six months in the campus quality assurance meetings (QAPI). Any identified issues will be reviewed in detail by the QAPI committee and new processes put in place to ensure compliance with this regulation.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 2 of 4 doors to two outside courtyards of the facility were not mistaken as facility exits. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8	K 0293	**K293- Exit Signage** Compliance Date: 5/16/2023 **Immediate Intervention** The Director of Plant Operations installed “not an exit” signage on the 400-hall dining room door and middle courtyard door. The Director of Plant Operations was educated by the Executive Director NFPA 101 Exit Signage –	05/16/2023

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	inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect at least 15 residents, as well as staff and visitors. Findings include: Based on observations on 04/26/23 between 11:45 a.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operations and Director of Plant Operations from a sister facility, the following was noted: a. The 400 Hall dining room outside door to the courtyard was not posted with a NO EXIT sign. This door also required a key to open. Based on interview at the time of the observation, the facility's Director of Plant Operations said this door was not a required exit and agreed there should be a "NO EXIT" sign on the door. b. The Service Hall outside door to the courtyard was not posted with a NO EXIT sign. Based on interview at the time of the observation, the facility's Director of Plant Operations said this door was not a required exit and agreed there should be a "NO EXIT" sign on the door. This finding was reviewed with both Director's of Plant Operations during the exit conference. 3.1-19(b)		2012 Existing on 5/16/2023. Exit and directional signs are displayed in accordance with 7.10.8.3.1. The deficient practice did not affect legacy residents or staff but has the potential to affect all.	
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,			

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	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 1. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler systems in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on record review on 04/26/23 between 8:45 a.m. and 11:45 a.m. with the Director of Plant Operations and Director of Plant Operations from a sister facility present, the quarter sprinkler inspection report dated 08/29/22 for the "Wet Pipe" indicated the Antifreeze test had failed. At note #2, it read "Antifreeze System Ground Southwest Mechanical Room System #2 Failed Test. Does not meet 22 degrees testing. Facility is aware of antifreeze deficiencies". Furthermore, at note #3, it read "Antifreeze System Ground Southwest Mechanical Room System #1 Failed Test. Does not meet 22 degrees testing. Facility is aware of antifreeze deficiencies". Based on interview at the time of the record review, the facility's Director of Plant Operations	K 0353	**K353** **K353—Anti-Freeze Testing** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the deficient practice. DPO was educated on NFPA 25 regarding maintaining water-based fire protection systems. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All Residents have the potential to be affected by the deficient practice. **What measures will be put into place and what systemic changes will be made to**	06/09/2023

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	155671	A. BUILDING 01 B. WING	04/26/2023

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	said the facility was aware of the deficiency and was working to get it resolved by the sprinkler inspection vendor. This finding was reviewed with both Director's of Plant Operations during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 8 smoke compartments and 1 of 7 covered overhangs were covered with corrosion or loaded, were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect kitchen staff and up to 13 resident, as well as staff and visitors in the 400 hall. Findings include: Based on observations on 04/26/23 between 11:45 a.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operations and Director of Plant Operations from a sister facility, the following was noted: a. There was one sprinkler head in the Janitor's Closet within the kitchen covered with corrosion. b. There was one sprinkler head under 400 Hall exit overhang covered with corrosion/loading (a black substance).		**ensure that the deficient practice does not recur.** DPO contacted contractor to repair and contractor is scheduled to be out on 6/5/2023. Annual testing in the fall of 2023; DPO will report any deficiencies found from inspection to ED. DPO/ED will work with Facilities Management to resolve deficiencies found from annual inspection. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The DPO will communicate to ED and Facilities Management once sprinkler contractor has replaced antifreeze. **K353- Corrosion on Sprinkler head** Immediate intervention The Director of Plant Operations contacted the sprinkler system contractor to come and replace the sprinkler heads on 400 hall exit overhang and it was repaired on 5/16/2023. The Director of Plant Operations was educated by the Executive Director on K 353 NFPA 101 Sprinkler System – Maintenance and Testing.	

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	Based on interview at the time of each observation, the facility's Director of Plant Operations agreed the previously mentioned sprinkler heads were covered with corrosion/loading and should be replaced. This finding was reviewed with both Director's of Plant Operations during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure the ceiling in 1 of 8 sprinklered smoke compartments was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect at least 20 residents, staff, and visitors. Findings include: Based on observations on 04/26/23 between 11:45 a.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operations and Director of Plant Operations from a sister facility, there was a 3/4 inch gap around a large cable wire penetrating the ceiling in the 600 Hall sprinkler riser room. The 3/4 inch gap was not properly fire stopped. Based on interview at the time of observation, the facility's Director of Plant Operations acknowledged the 3/4 inch gap as said it would be fire stopped as soon as possible. This finding was reviewed with both Director's of Plant Operations during the exit conference. 3.1-19(b) 4. Based on observation and interview, the facility failed to ensure 2 of 2 sprinkler systems spare sprinkler cabinets were properly maintained.		LSC 9.7.5 NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent or sidewall). Furthermore at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. The Director of Plant Operations will inspect facility sprinkler heads for any signs of leakage, corrosion, or other damage and react appropriately as needed. The deficient practice did not affect any residents or staff but has the potential to affect all parties. **K353- Wire penetrating ceiling in sprinkler riser room.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** No residents were affected by the deficient practice. DPO was educated on the importance of not	

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	NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observations on 4/26/23 between 11:45 a.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operations and Director of Plant Operations from a sister facility, both spare sprinkler cabinets in the two sprinkler riser rooms had seven spare sprinkler heads laying loosely and not in slots, which could cause breakage to the sprinkler heads if falling out when opening the cabinet door. Based on interview at the time of each observation, the facility's Director of Plant Operations acknowledged the two spare sprinkler cabinets were not large enough for the number of spare sprinkler heads in the current cabinets. This finding was reviewed with both Director's of Plant Operations during the exit conference. 3.1-19(b)		having any penetrations on a fire wall. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All Residents have the potential to be affected by the deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** DPO fire caulked the ceiling in the 600-hall sprinkler riser room where the gap was noted to be located. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The DPO survey campus for any other areas of penetration and take actions as needed. **Completion Date: 5/16/2023** **K353—Spare Sprinkler Head Cabinets** **What corrective action(s) will**	

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			be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by the deficient practice. DPO educated on NFPA 25, 2011 Edition, Section 5.4.1.4 relating to spare sprinkler head storage. DPO ordered additional sprinkler head storage cabinets. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All Residents have the potential to be affected by the deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** DPO educated on proper sprinkler head storage. DPO to conduct audits to ensure interventions stay in place.	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills			

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	Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure 1 of 12 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 04/26/23 between 8:45 a.m. and 11:45 a.m. with the Director of Plant Operations and Director of Plant Operations from a sister facility present, the 09/29/22 fire drill performed during the third shift at 3:30 a.m. was not provided with documentation for the transmission of the alarm to the monitoring company. Based on interview at the time of record review, the facility's Director of Plant Operations acknowledged there was no information on the 09/29/22 fire drill report to verify that transmission of the alarm was received by the monitoring company. This finding was reviewed with both Director's of	K 0712	**K712- Fire Drills** Completion Date: 5/16/2023 1. No residents were affected by the alleged deficient practice. 2. All residents have the potential to be affected. DPO educated on fire drill process (transmission, signatures, and the fire drill report) on 5/16/2023. DPO conducted a simulated fire drill on 9/29/22 but did not pull alarm during waking hours the next day which is what the deficient practice was. Fire alarm report shows that other subsequent drills being transmitted to vendor. 3. As a measure of ongoing compliance, the ED or designee will complete an audit for verification of all documents of the fire drill process are completed 1x/month x6 months. 4. As a quality measure, the ED or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred	05/16/2023

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	Plant Operations during the exit conference. 3-1.19(b)		percent compliance in the campus Quality Assurance Performance Improvement meetings.	
K 0914 SS=E Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review, and interview; the facility failed to ensure all nonhospital-grade electrical receptacles in 10 of 62 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	K 0914	**K914 – Electrical Systems – Maintenance and Testing** Compliance Date: 5/9/2023 **Immediate Intervention** The Director of Plant Operations has begun testing all electrical outlets on the 200 hall on 4/27/2023 and has completed all	05/09/2023

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	general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect at least 20 residents. Findings include: Based on record review on 04/26/23 between 8:45 a.m. and 11:45 a.m. with the Director of Plant Operations and Director of Plant Operations from a sister facility present, there was no record of an annual test during the past 12 month period for the ten 200 Hall resident rooms electrical receptacles that were not hospital-grade receptacles available for review. Based on interview at the time of record review, the facility's Director of Plant Operations said she tested all other resident room electrical receptacles, but must have missed the 200 Hall resident rooms. Based on observations between 11:45 a.m. and 2:30 p.m. during a tour of the facility with both Director's of Plant Operations there were at least four to six electrical receptacles in each resident room in the 200 Hall. This finding was reviewed with both Director's of Plant Operations during the exit conference. 3.1-19(b)		testing. DPO had completed all electrical outlet testing for rest of campus prior to Life Safety visit. The Director of Plant Operations was educated by the Executive Director on NFPA 99- 2012 Edition Electrical Systems – Maintenance and Testing of receptacles. The Director of Plant Operations will conduct inspection and testing of non-hospital grade electrical outlets once per year on all resident care areas and act appropriately as needed. No residents were affected by this deficient practice but have the potential to affect all residents of the facility.	

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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 provide complete documentation for the	K 0918	**K 918 – Electrical Systems – Essential Electric Systems**	05/09/2023

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	testing of 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: Based on record review on 04/26/23 between 8:45 a.m. and 11:45 a.m. with the Director of Plant Operations and Director of Plant Operations from a sister facility present, the facility provided documentation for a four hour test of the emergency generator on 04/05/23, however, the documentation provided did not include the calculation for the percentage of load during the four hour load test. This was confirmed by the facility's Director of Plant Operations at the time of record review. This finding was reviewed with both Director's of Plant Operations during the exit conference. 3.1-19(b)		**Maintenance and Testing** Compliance Date- 5/5/2023 DPO was educated by the Executive Director on K 918 NFPA 101 Electrical Systems – Essential Electrical Systems Maintenance and Testing in regard to documenting load every hour while conducting 4-hour load test. A 4-hour load test had been conducted by DPO on 9/19/2022 but did not include the hourly load calculations. DPO conducted a 4-hour load test again on 5/5/2023 to include load calculations once every hour for the 4-hour test. DPO will document test in TELS. ED will audit for completion. The deficient practice did not affect any residents but has the potential to affect all.	