STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155820	A. BUILDING -- B. WING	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE LINCOLN	1236 LINCOLN AVE EVANSVILLE, IN 47714

(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 Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/26/24 Facility Number: 000443 Provider Number: 155820 AIM Number: 100289580 At this Emergency Preparedness survey, Aperion Care Lincoln was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 47 certified beds, with a current census of 36. Quality Review completed on 04/03/24 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	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 respectively requests the 2567 plan of correction to be considered our allegation of compliance **effective April 20, 2024** to the State findings of the Annual survey conducted on March 26, 2024. We respectfully request a desk review in lieu of a post-survey review.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Teri McNeely	Administrator	04/18/2024

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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	OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise			

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	the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice			

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

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

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

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

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

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	onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and			

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	maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following:	E 0039	*What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?* Although no specific residents were affected, all residents have the potential to be affected by the alleged deficient practice. On 4-2-2024 there was a tornado warning and our building received damage from the storm. We worked as a group, including the Fire Marshall, Dispatch and Center Point energy company to ensure our residents were not affected by the damage and subsequent loss of electricity. We had all departments working together to ensure residents had food, water and care as needed	04/20/2024

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	a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants in the facility. Findings include: Based on review of the Emergency Preparedness plan on 03/26/24 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director and Administrator present, the facility was able to provide documentation of a table top exercise dated 03/08/24, however, they were unable to provide documentation of a community based exercise or documentation of an emergency event during the past 12 months. Based on interview at the time of record review, the Administrator said no Community Based Exercise or Emergency Event documentation was available to review during the past twelve month period. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		despite the potential issues that arose. *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective actions will be taken?* Although no specific residents were affected, all residents have the potential to be affected by the alleged deficient practice. On 4-2-2024 there was a tornado warning and our building received damage from the storm. We worked as a group, including the Fire Marshall, Dispatch and Center Point energy company to ensure our residents were not affected by the damage and subsequent loss of electricity. We had all departments working together to ensure residents had food, water and care as needed despite the potential issues that arose. The Maintenance Director will work with community groups to set up additional in-house trainings outside of natural occurring events. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* The Maintenance Director will be in-serviced to show understanding that Emergency Plan exercises must be completed per regulation and completed outside of any natural occurring events.	

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			How will the corrective actions be monitored to ensure the alleged deficient practice will not recur (ie what quality assurance program will be put into place? Maintenance Director/designee will complete an audit tool related to discussion over needed exercises and opportunities to complete Emergency Plan readiness moving forward. This tool will be completed by Maintenance Director/designee weekly for eight weeks and monthly for four months. The outcome of this tool will be reviewed at the Quality Assurance meeting to determine if any additional action is warranted.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The			

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	generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the 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			

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	155820	A. BUILDING -- B. WING	03/26/2024

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	(NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (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	E 0041	*What corrective actions will be*	04/20/2024

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	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 (36 months). 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 03/26/24 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director present, the facility was unable to provide documentation of a four hour load test of the emergency generator conducted within the past 36 month period. This was confirmed by the Maintenance Director at the time of record review. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		*accomplished for those residents found to have been affected by the alleged deficient practice?* Although no specific residents were affected, all residents have the potential to be affected by the alleged deficient practice. A load test of 4 hours will be completed by Evapar on 4-19-2024 to meet criteria of completion. *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective actions will be taken?* Although no specific residents were affected, all residents have the potential to be affected by the alleged deficient practice. A load test of 4 hours will be completed by Evapar on 4-19-24 to meet criteria of completion. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* An in-service was completed with Maintenance Director explaining need for a 4 hour load test with the generator during the 36-month period per regulation and proof that it has been completed properly kept in binder to show for Life Safety review. *How will the corrective actions be monitored to ensure the alleged deficient practice will not recur (ie what quality assurance program will be put into place?*	

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			Maintenance Director/designee will complete an audit tool related to ensuring that a load test has been completed per regulation and additional tests will be done if necessary within next 36 months. This tool will be completed by Maintenance Director/designee weekly for eight weeks and monthly for four months. The outcome of this tool will be reviewed at the Quality Assurance meeting to determine if any additional action is warranted.	
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: 03/26/24 Facility Number: 000443 Provider Number: 155820 AIM Number: 100289580 At this Life Safety Code survey, Aperion Care Lincoln was found not in compliance with Requirements for Participation in 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 two story facility with a ground level was determined to be of Type II (222) construction and	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 respectively requests the 2567 plan of correction to be considered our allegation of compliance **effective April 20, 2024** to the State findings of the Annual survey conducted on March 26, 2024. We respectfully request a desk review in lieu of a post-survey review.	

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	was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors on all levels including the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 47 and had a census of 36 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered, except one brick framed garage used for facility storage. Quality Review completed on 04/03/24			
K 0225 SS=E Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Based on observation and interview, the facility failed to ensure 1 of 5 sets of stairway enclosure doors would close completely and latch. This deficient practice could affect at least 10 residents, staff, and visitors. Findings include: Based on observations on 03/26/24 between 3:00 p.m. and 5:15 p.m. during a tour of the facility with Maintenance Director, the set of stairway double doors at ground level between the front lobby and lobby stairs was equipped with a coordinator. When tested several times, the doors did not close completely and latch due to the coordinator arm being set to low and not rolling up the second door to close. There was a six inch gap between the doors when closed to their fullest. Based on interview at the time of observation, the Maintenance Director acknowledged the set of	K 0225	*What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?* Although no specific residents were affected, all residents have the potential to be affected by the alleged deficient practice. The stairway coordinator was fixed and the doors are able to close and completely latch now. *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective actions will be taken?* Although no specific residents were affected, all residents have the potential to be affected by the alleged deficient practice. The	04/20/2024

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	stairway double doors between the front lobby and the lobby stairway did not close completely and latch due to the coordinator arm being set to low on the door frame. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		stairway coordinator was fixed and the doors are able to close and completely latch now. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* An in-service was completed with the Maintenance Director related to making sure the coordinator on all stairway enclosures are checked regularly so that they close and latch appropriately. *How will the corrective actions be monitored to ensure the alleged deficient practice will not recur (ie what quality assurance program will be put into place?* Maintenance Director/designee will complete an audit tool related to ensuring that all enclosure doors are set accordingly to allow for closing and latching as expected. This tool will be completed by Maintenance Director/designee weekly for eight weeks and monthly for four months. The outcome of this tool will be reviewed at the Quality Assurance meeting to determine if any additional action is warranted.	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:			

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	* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure the cook top for 1 of 1 stove in the Break Room was shut off at the switch when not in use. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop	K 0324	*What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?* Although no specific residents were affected, all residents have the potential to be affected by the alleged deficient practice. The stove has been turned off at the breaker and has signs posted showing it is inoperable at this time. *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective actions will be taken?* Although no specific residents were affected, all residents have the potential to be affected by the alleged deficient practice. The stove has been turned off at the	04/20/2024

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	or range whenever the kitchen is not under staff supervision. This deficient practice could affect at least one resident, staff and visitors while in the Break Room. Findings include: Based on observations on 03/26/24 between 3:00 p.m. and 5:15 p.m. during a tour of the facility with the Maintenance Director, there was a cooktop stove in the ground level general Break Room. The corridor doors to this room were kept open at all times. The stove was not being used at the time of observation and the power to the stove was on. Based on interview at the time of observation, the Maintenance Director confirmed the cooktop stove was not deactivated when not in use, furthermore, the Maintenance Director said he didn't think there was a deactivation switch for the Break Room stove other than unplugging it from the receptacle. The Maintenance Director also said he didn't think the Break Room cooktop stove is ever used by staff or residents. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		breaker and has signs posted showing it is inoperable at this time. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* An in-service was completed with the Maintenance Director related to checking cooking areas in the building that are not in use and securing the safety of the device by having it turned off and disabled for use. *How will the corrective actions be monitored to ensure the alleged deficient practice will not recur (ie what quality assurance program will be put into place?* Maintenance Director/designee will complete an audit tool related to ensuring that any cooking devices that need to be disabled are off and not being used. This tool will be completed by Maintenance Director/designee weekly for eight weeks and monthly for four months. The outcome of this tool will be reviewed at the Quality Assurance meeting to determine if any additional action is warranted.	
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			

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	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 1. Based on record review and interview, the facility failed to ensure documentation was available to show that all smoke detectors were sensitivity tested within the past 24 month period. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the	K 0345	*What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?* Although no specific residents were affected, all residents have the potential to be affected by the alleged deficient practice. A call was placed to complete the smoke detector sensitivity testing that had not been done within last 24 months. This was completed on 3/30/24. The Maintenance Director completed an itemized list showing where each of the devices connected to the fire alarm system was located. *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective actions will be taken?* Although no specific residents were affected, all residents have the potential to be affected by the alleged deficient practice. A call was placed to complete the smoke detector sensitivity testing that had not been done within last 24 months. This will be completed and back in compliance by 4-20-24. The Maintenance Director completed an itemized list	04/20/2024

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	listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 03/26/24 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director present, the facility was unable to produce a smoke detector sensitivity report for all smoke detectors for the past 24 month period. Based on interview at the time of record review, the Maintenance Director confirmed there was no smoke detector sensitivity testing documentation available for the past 24 months. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors,		showing where each of the devices connected to the fire alarm system was located. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* An in-service was completed with the Maintenance Director related to completion of smoke detector sensitivity documentation and how it needs to be available in Life Safety binder showing it is done within 24 months to meet requirements. He was in-serviced on maintaining an up to date itemized list of devices connected to the fire alarm system. *How will the corrective actions be monitored to ensure the alleged deficient practice will not recur (ie what quality assurance program will be put into place?* Maintenance Director/designee will complete an audit tool related to ensuring that smoke detector sensitivity has been completed and itemized list of devices connected to fire alarm system is up to date. This tool will be completed by Maintenance Director/designee weekly for eight weeks and monthly for four months. The outcome of this tool will be reviewed at the Quality Assurance meeting to determine if any additional action is warranted.	

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	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 03/26/24 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director present, there was documentation provided regarding an annual fire alarm system inspection dated 03/20/24 by the facility's fire alarm inspection vendor, furthermore, there were semi-annual visual inspection documents labeled "Annual Visual Inspection of Fire Equipment" date 07/27/23 and 01/29/24 that were performed by the facility's maintenance personnel. These two inspection documents only listed the number of devices connected to the fire alarm system in each of the facility's smoke compartments, and was not an itemized list of where each device was located. Based on interview at the time of record review, the Maintenance Director agreed the semi-annual inspection documents did not provide an itemized list of each device connected to the facility's fire alarm system. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall			

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	be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete written policy for the protection of all occupants indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants in the facility. Findings include: Based on record review on 03/26/24 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director present, the facility provided fire watch documentation, however, it was incomplete. The plan failed to include information about the fire alarm system being placed out of service for four hours or more in a twenty four hour period. Based on interview at the time of record review, the Maintenance Director confirmed the fire watch lacked information about the fire alarm system being placed out of service for four hours or more in a twenty four hour period. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0346	*What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?* Although no specific residents were affected, all residents have the potential to be affected by the alleged deficient practice. The policy related to fire watch or the alarm system being out of service was updated to reflect the requirement. *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective actions will be taken?* Although no specific residents were affected, all residents have the potential to be affected by the alleged deficient practice. The policy related to fire watch or the alarm system being out of service was updated to reflect the requirement. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* An in-service was completed with the Maintenance Director related to using the updated policy and procedure information to meet the	04/20/2024

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			out of service requirement. *How will the corrective actions be monitored to ensure the alleged deficient practice will not recur (ie what quality assurance program will be put into place?* Maintenance Director/designee will complete an audit tool related to using the updated policy and teaching staff as needed on expectation . This tool will be completed by Maintenance Director/designee weekly for eight weeks and monthly for four months. The outcome of this tool will be reviewed at the Quality Assurance meeting to determine if any additional action is warranted.	
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed for the	K 0354	*What corrective actions will be accomplished for those residents found to have been affected by*	04/20/2024

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	protection of all occupants in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 03/26/24 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director present, the facility provided fire watch documentation, however, it was incomplete. The plan failed to include information about the sprinkler system being placed out of service for ten hours or more in a twenty four hour period. Based on interview at the time of record review, the Maintenance Director confirmed the fire watch lacked information about the sprinkler system being placed out of service for ten hours or more in a twenty four hour period. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		*the alleged deficient practice?* Although no specific residents were affected, all residents have the potential to be affected by the alleged deficient practice. The policy related to the sprinkler system being out of service was updated to reflect the requirement. *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective actions will be taken?* Although no specific residents were affected, all residents have the potential to be affected by the alleged deficient practice. The policy related to the sprinkler system being out of service was updated to reflect the requirement. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* An in-service was completed with the Maintenance Director related to using the updated policy and procedure information to meet the out of service requirement. *How will the corrective actions be monitored to ensure the alleged deficient practice will not recur (ie what quality assurance program will be put into place?* Maintenance Director/designee will complete an audit tool related to using the updated policy and teaching staff as needed on expectation . This tool will be	

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	3.1-19(b)		completed by Maintenance Director/designee weekly for eight weeks and monthly for four months. The outcome of this tool will be reviewed at the Quality Assurance meeting to determine if any additional action is warranted.	
K 0511 SS=D 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 service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure electrical wiring was protected in 1 of 1 first floor shower room. 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. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect one resident and staff. Findings include: Based on observations on 03/26/24 between 3:00 p.m. and 5:15 p.m. during a tour of the facility with the Maintenance Director, the wall mounted electrical receptacle in the first floor shower room was missing a cover. Based on interview at the time of observation, the Maintenance Director acknowledged the missing cover from the	K 0511	*What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?* Although no specific residents were affected, all residents have the potential to be affected by the alleged deficient practice. The faceplate cover was replaced by Maintenance Director on 3-27-24. *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective actions will be taken?* Although no specific residents were affected, all residents have the potential to be affected by the alleged deficient practice. The faceplate cover was replaced by Maintenance Director on 3-27-24. *What measures will be put into*	04/20/2024

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	electrical receptacle on the wall in the first floor shower room and said he would have a new cover on by the end of the day. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		*place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* An in-service was completed with the Maintenance Director related to checking all covers of electrical receptacles so they meet requirement and are in place. *How will the corrective actions be monitored to ensure the alleged deficient practice will not recur (ie what quality assurance program will be put into place?* Maintenance Director/designee will complete an audit tool related to ensuring that all covers are in place appropriately with electrical receptacles. This tool will be completed by Maintenance Director/designee weekly for eight weeks and monthly for four months. The outcome of this tool will be reviewed at the Quality Assurance meeting to determine if any additional action is warranted.	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills 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			

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	audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 3 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 03/26/24 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director present, 3 of 4 third shift (night) fire drills were performed between 12:00 a.m. and 12:05 a.m. Based on interview at the time of record review, the Maintenance Director acknowledged the times the third shift fire drills were performed and agreed the times were not varied enough. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	*What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?* Although no specific residents were affected, all residents have the potential to be affected by the alleged deficient practice. Fire drills have now been conducted on shifts with appropriate time variance to meet requirement. *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective actions will be taken?* Although no specific residents were affected, all residents have the potential to be affected by the alleged deficient practice. Fire drills have now been conducted on shifts with appropriate time variance to meet requirement. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* An in-service was completed with the Maintenance Director related to creating a fire drill program and supporting documentation that meets the requirement for varied times. *How will the corrective actions be monitored to ensure the alleged deficient practice will not recur (ie what quality assurance program*	04/20/2024

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			will be put into place? Maintenance Director/designee will complete an audit tool related fire drills being completed according to requirement. This tool will be completed by Maintenance Director/designee weekly for eight weeks and monthly for four months. The outcome of this tool will be reviewed at the Quality Assurance meeting to determine if any additional action is warranted.	
K 0761 SS=F Bldg. 01	Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 7 of 7 single stairway fire door assemblies, 5 of 5 double stairway fire door assemblies, and 4 of 4 laundry chute/trash chute door assemblies was 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, 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	K 0761	*What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?* Although no specific residents were affected, all residents have the potential to be affected by the alleged deficient practice. An annual audit was completed by Maintenance Director to show documentation related to stairway door assemblies and laundry/trash chutes door assemblies. *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective actions will be taken?* Although no specific residents were affected, all residents have the potential to be affected by the alleged deficient practice. An annual audit was completed by	04/20/2024

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	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. This deficient practice could affect all residents, as well as staff, and visitors. Findings include: Based on record review on 03/26/24 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director		Maintenance Director to show documentation related to stairway door assemblies and laundry/trash chutes door assemblies. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* An in-service was completed with the Maintenance Director related to annual inspection of all fire door assemblies. *How will the corrective actions be monitored to ensure the alleged deficient practice will not recur (ie what quality assurance program will be put into place?* Maintenance Director/designee will complete an audit tool related to ensuring that documentation is up to date and changed if any variances in building set up. This tool will be completed by Maintenance Director/designee weekly for eight weeks and monthly for four months. The outcome of this tool will be reviewed at the Quality Assurance meeting to determine if any additional action is warranted.	

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	present, the facility was able to provide documentation for the annual inspection of all sets of the facility's smoke barrier door assemblies and oxygen transfilling room fire door assembly, however, the facility was unable to provide documentation for an annual inspection of all stairway fire door assemblies and 4 laundry chute/trash chute fire door assemblies. Based on interview at the time of record review, the Maintenance Director said there was no documentation of an annual inspection of the facility's stairway and laundry chute/trash chute fire door assemblies. Based on observations during a tour of the facility with the Maintenance Director between 3:00 p.m. and 5:00 p.m., there were 7 single, and 5 double stairway fire door assemblies and 4 laundry chute/trash chute fire door assemblies noted in the facility. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly,			

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	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 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 (36 months). 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.	K 0918	*What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?* Although no specific residents were affected, all residents have the potential to be affected by the alleged deficient practice. A load test of 4 hours will be completed by Evapar by 4-19-2024 to meet criteria of completion. *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective actions will be taken?* Although no specific residents	04/20/2024

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	Findings include: Based on record review on 03/26/24 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director present, the facility was unable to provide documentation of a four hour load test of the emergency generator conducted within the past 36 month period. This was confirmed by the Maintenance Director at the time of record review. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		were affected, all residents have the potential to be affected by the alleged deficient practice. A load test of 4 hours will be completed by Evapar by 4-19-2024 to meet criteria of completion. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* An in-service was completed with Maintenance Director explaining need for a 4 hour load test with the generator during the 36-month period per regulation and proof that it has been completed properly kept in binder to show for Life Safety review. *How will the corrective actions be monitored to ensure the alleged deficient practice will not recur (ie what quality assurance program will be put into place?* Maintenance Director/designee will complete an audit tool related to ensuring that a load test has been completed per regulation and additional tests will be done if necessary within next 36 months. This tool will be completed by Maintenance Director/designee weekly for eight weeks and monthly for four months. The outcome of this tool will be reviewed at the Quality Assurance meeting to determine if any additional action is warranted.	