STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING -- B. WING	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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: 01/09/24 Facility Number: 000245 Provider Number: 155354 AIM Number: 1002890800 At this Emergency Preparedness survey, Newburgh Health Care was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 114 certified beds. At the time of the survey, the census was 64. Quality Review completed on 01/16/24 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 requests that the plan of correction be considered our allegation of compliance effective February 2, 2024 to the annual licensure survey conducted January 9th, 2024. We respectfully request a paper compliance/desk review.	
E 0024 SS=C Bldg. --	403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 482.15(b)(6), 483.475(b)(6), 483.73(b)(6), 484.102(b)(5), 485.625(b)(6), 485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5) Policies/Procedures-Volunteers and Staffing §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ally Lopp	Assistant Administrator	01/31/2024

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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	[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for	E 0024	Corrective Actions Taken: No residents were harmed. All others with potential to be affected: No residents were	02/23/2024

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	integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Manual on 01/09/24 between 9:30 a.m. and 1:00 p.m. with the Assistant Administrator present, the facility's plan did not address the use of volunteers in an emergency. Based on interview at the time of review, the Assistant Administrator confirmed the plan provided did not address the use of volunteers in an emergency. This finding was reviewed with the Administrator, Assistant Administrator, and Maintenance Director during the exit conference.		harmed. Measures to prevent reoccurrence: We have updated a policy that includes the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency. This volunteer policy was added to our Emergency Preparedness Binder. Please see attached policy. Monitoring corrective action: This policy will be reviewed along with the Emergency Preparedness Plan annually.	
E 0026 SS=C Bldg. --	403.748(b)(8), 416.54(b)(6), 418.113(b)(6)(C)(iv), 441.184(b)(8), 482.15(b)(8), 483.475(b)(8), 483.73(b)(8), 485.625(b)(8), 485.920(b)(7), 494.62(b)(7) Roles Under a Waiver Declared by Secretary §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2			

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	years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.73(b)(8). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Manual on 01/09/24 between 9:30 a.m. and 1:00 p.m. with the Assistant Administrator present, the plan did not address the role of the LTC facility under a waiver declared by the Secretary. Based on interview at the time of record review, the Assistant Administrator acknowledged the available plan did not address the role of the LTC facility under a waiver declared by the Secretary.	E 0026	=”” span=”” no=”” residents=”” were=”” harmed.<=””>Corrective actions taken: No residents were harmed. =”” span=”” no=”” residents=”” were=”” harmed.<=””>All others with potential to be affected: No residents were harmed. =”” span=”” no=”” residents=”” were=”” harmed.<=””>Measures to prevent reoccurrence: Our emergency preparedness policies and procedures were updated to include the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.73(b)(8)	02/23/2024

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	This finding was reviewed with the Administrator, Assistant Administrator, and Maintenance Director during the exit conference.		=”” span=”” no=”” residents=”” were=”” harmed.<=””>Monitoring corrective action: This policy will be reviewed along with our Emergency Preparedness Plan annually.	
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 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.			

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	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 (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.			

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	(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 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 maintain a complete written record of monthly generator load testing for 1 of 1 generator during 2 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA	E 0041	Corrective actions taken: On 1/25/2024 the Assistant Administrator in-serviced the Maintenance Supervisor/designee on the requirement that monthly load testing of the emergency generator must be completed, and documentation retained in the LSC Binder to meet set standards. On 1/25/2024 the Assistant Administrator in-serviced the Maintenance Supervisor/designee on the requirement that weekly testing for the generator must be	02/23/2024

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	110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection and testing reports on 01/09/24 between 9:30 a.m. and 1:00 p.m. with the Maintenance Director present, there was no monthly generator load test documentation available for October and November of 2023 for the emergency generator, furthermore, there was monthly generator load test documentation for May and December of 2023, however, there was no date recorded for each of those two months. Based on interview at the time of record review, the Maintenance Director said the emergency generator runs a full load automatically every week, but, confirmed		conducted every week and documentation retained in the LSC Binder to meet set standards. The facilities certified generator company was contacted and visited our facility on 1/29/2024 at 8am to complete training on the weekly testing and inspection and the monthly load testing of the emergency generator with the Maintenance Director, Maintenance Assistant and Assistant Administrator one time to further educate. All others with potential to be affected: All residents, staff and visitors could be affected but none were. The facility has only one emergency generator. Measures to prevent reoccurrence: Maintenance Supervisor/Designee will inspect and test the emergency generator weekly and perform monthly load testing as required and retain documentation of those tests and inspections in the facility's LSC Binder as a part of the facilities Preventive Maintenance Program and document those inspection results as appropriate (see attachment A). If any issues are discovered, the will be address and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. The Administrator/designee will	

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	there was no emergency generator load test documentation for October and November of 2023, and no recorded date of the load tests during May and December of 2023. This finding was reviewed with the Administrator, Assistant Administrator, and Maintenance Director during the exit conference.		monitor adherence to the preventative maintenance schedule and validate the preventive maintenance documentation in place via a Life Safety Code checklist. Monitoring corrective action: The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting every month for 6 months. The audit will be reviewed by the QA/PI committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulator requirements.	
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: 01/09/24 Facility Number: 000245 Provider Number: 155354 AIM Number: 100290800	K 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of	

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	At this Life Safety Code survey, Newburgh Health Care was found not 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 (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 114 and had a census of 64 at the time of this survey. All areas where the residents have customary access were sprinklered, and all areas providing facility services, including a detached garage used for a maintenance shop and maintenance and facility storage, were sprinklered, except a small detached wood framed shed used for furniture storage and a walk in cooler outside the kitchen service hall exit. Quality Review completed on 01/16/24		correction be considered our allegation of compliance effective February 2, 2024 to the annual licensure survey conducted January 9th, 2024. We respectfully request a paper compliance/desk review.	
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review, observation, and interview; the facility failed to ensure there was documentation for the testing of 1 of 1 battery	K 0291	=”” p=””> =”” p=””>All others with potential to be affected: The Maintenance	02/23/2024

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	backup lights that were tested monthly for 30 seconds during 12 of the past 12 months, and annually for 90 minutes during the past 12 months to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review on 01/09/24 between 9:30 a.m. and 1:00 p.m. with the Maintenance Director present, the facility did not have a preventative maintenance (PM) report that the battery powered emergency light located on the outside wall of the walk-in freezer next to the emergency generator was tested monthly for 30 seconds during the past 12 month period. Furthermore, there was no documentation available to show the battery powered emergency light was tested annually for 90 minutes during the past 12 month period. Based on an interview at the time of record review, this was confirmed by the Maintenance Director. During a tour of the facility with the Maintenance Director between 1:00 p.m. and 3:00 p.m., the facility was equipped with one emergency battery powered light unit near the emergency generator.		Director was in-service on 1/25/2024 of the requirement to check the battery-operated emergency light. MEASURES TO PREVENT REOCCURRENCE: The facility has obtained a new audit form (see attachment B) for the battery-operated emergency light. A 30-second monthly log and 90-minute annual log was set up and itemized to include the battery-powered emergency light by the emergency generator. The Logbook of the battery backup lights will be tested monthly, and findings documented monthly. January had its 30-second monthly test on 1-25-2024. Monitoring corrective action: The itemized log/documentation will be reviewed by the ED/Designee for completion as required and will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting every month for 6 months. The audit will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all	

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	This finding was reviewed with the Administrator, Assistant Administrator, and Maintenance Director during the exit conference. 3.1-19(b)		regulatory requirements.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe			

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	Hazard - see K322) Based on observation and interview, the facility failed to ensure 2 of over 10 hazardous area doors, such as a laundry room door and a storage room door, would close completely and latch automatically, or was not prevented from closing with an impediment. This deficient practice could affect all residents while in the dining room which was in the same smoke compartment as the laundry room. Findings include: Based on observations on 01/09/24 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. The north hall Supply Room door was provided with a self closing device, however, the door was held wide open with a door wedge. The door was observed held wide open with the door wedge during the initial entrance tour and again during the official tour with the Maintenance Director. The north hall Supply Room was over 50 square feet in size and filled with several shelves full of cardboard boxes, paper, plastic, and packages of adult diapers. b. The south laundry room door would not close completely and latch when tested. There was a three inch gap between the full length of the door and its frame when it closed fully. Based on interview at the time of each observation, this was acknowledged by the Maintenance Director. This finding was reviewed with the Administrator, Assistant Administrator, and Maintenance Director during the exit conference. 3.1-19(b)	K 0321	=" " p=" ">CORRECTIVE ACTIONS TAKEN: The self-closing device of the door into the laundry room was repaired and is closing automatically. =" " p=" ">All others with potential to be affected: Residents that reside at the facility may be affected by the alleged deficient practice. All self-closing doors in the facility were checked to ensure proper closure. Each self-closing door will be checked weekly by the Maintenance Director/Designee and Administrator, if issues arise our HVAC company will be contacted for further assistance. (See attachment C). Measures to prevent reoccurrence: Maintenance Supervisor will ensure all self- closing doors close properly, and immediate measures will be taken to correct any door that does not meet the standard. Monitoring corrective action: The Maintenance Director will check all self-closing doors weekly to ensure proper closing. The checklist will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting every month for 6 months. The audit will be reviewed by the QA/PI	02/23/2024

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			Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Corrective actions taken: No residents currently reside on this unit. The Maintenance Director removed the wedge when notified. ALL OTHERS WITH POTENTIAL TO BE AFFECTED: All staff will receive in-service on door safety, self-closing devices, use of wedges to hold doors open, and propping doors open with trash cans or other devices. MEASURES TO PREVENT REOCCURRENCE: The Maintenance Director will conduct additional visual rounds to ensure self-closing doors are not propped open. This information will be kept for QA purposes. As needed additional training will be provided to staff. Monitoring corrective action: Audits of rounds and education/logs will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting every month for 6 months. The audit will be reviewed by the QA/PI	

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			Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. ="" p="">	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure the ceiling in 2 of 14 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:	K 0353	="" span="" no="" residents="" affected<="">Corrective actions taken: No residents affected ="" span="" no="" residents="" affected<=""> All others with potential to be affected: All staff will be	02/23/2024

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	Based on observations on 01/09/24 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. There were two, half inch gaps around metal conduits penetrating the ceiling in the west nurses' station medical supply room that were not properly fire stopped. b. There was a half inch gap on one side of the ceiling mounted sprinkler head that was not properly fire stopped in the supply room within the laundry room. Based on interview at the time of each observation, the Maintenance Director acknowledged the gaps penetrating the medical supply room ceiling and the storage room within the laundry room ceiling and said they would be fire stopped as soon as possible. This finding was reviewed with the Administrator, Assistant Administrator, and Maintenance Director during the exit conference. 3.1-19(b)		in-serviced on the importance of reporting cracks and holes in ceiling tiles though out facility. The maintenance director will conduct additional visual rounds to look for cracks/holes in the facility weekly (see attachment C). The affected areas were sealed with the appropriate fire caulk. The Sprinkler heads that had an open area were fixed with escutcheon rings. (See attached photos)Measures to prevent reoccurrence: Proper caulking will continue to be used by the Maintenance Supervisor and areas needing caulking will be reported via maintenance form. This will be reviewed by the administrator upon completion of caulking and quarterly thereafter. Ceiling tiles will be assessed for cracks quarterly and tiles will be replaced as needed.Monitoring corrective action: Audits of rounds and education/logs will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting every month for 6 months. The audit will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of	

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			correction constitutes our credible allegation of compliance with all regulatory requirements. ="" p="">	
K 0363 SS=F Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire			

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	resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 6 of 64 resident room corridor doors had no impediment to closing. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations on 01/09/24 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, resident room doors 10, 15, 16, 56, 59, and 61 were all held wide open with waste baskets. Based on interview at the time of each observation, the Maintenance Director acknowledged that the resident room doors previously mentioned were being held wide open with waste baskets. This finding was reviewed with the Administrator, Assistant Administrator, and Maintenance Director during the exit conference. 3.1-19(b)	K 0363	=”” spancorrective=”” taken:=”” the=”” maintenance=”” supervisor=”” immediately=”” removed=”” all=”” trash=”” cans=”” from=”” in=”” front=”” of=”” resident=”” doors.=”” tightened=”” door=”” hardware=”” to=”” allow=”” remain=”” open=”” with=”” no=”” prop=”” on=”” 1-10-2024. <=”” p=””> All others with potential to be affected: All staff will receive in-service on door safety, self-closing devices, use of wedges to hold doors open, and propping doors open with trash cans or other devices. The Maintenance supervisor will continue to tighten all door hardware to allow door to remain open with no prop. Measures to prevent reoccurrence: The Maintenance supervisor will conduct additional visual rounds to ensure doors are not propped or held open (see attachment C). If doors are found to be held with trash, the maintenance director will ensure the door does not need to be tightened. This information will be kept for QA purposes. As	02/23/2024

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			needed additional training will be provided to staff. Monitoring corrective action: Audits of rounds and education/logs will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting every month for 6 months. The audit will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.	
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 1 of over 10 wet locations, was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for	K 0511	=”” spancorrective=”” taken:=”” the=”” electricity=”” to=”” outlet=”” in=”” north=”” pantry=”” was=”” removed=”” and=”” wires=”” were=”” capped=”” off=”” then=”” covered=”” with=”” a=”” solid=”” plate.=”” (see=””	02/23/2024

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	personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in		attached="" photos). <="" p=""> All others with potential to be affected: All other areas where electric GFCI outlets are within 3 feet of a sink or water were tested to ensure proper working function and are protected by GFCI. Measures to prevent reoccurrence: The Maintenance Director will conduct testing of receptacles within 3 feet of water to ensure they are GFCI protected quarterly (see attachment C). Audits to be completed by Maintenance Director or designee. Monitoring corrective action: The audit of ensuring all receptacles near wet locations are protected with GFCI will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting every month for 6 months. The audit will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.	

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	patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect one staff while in the East Unit Clean Utility Room. Findings include: Based on observations on 01/09/24 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, the electric receptacle within three feet of the sink in the north hall Diet Kitchen was not provided with a GFCI receptacle. When tested with a GFCI testing device the receptacle did not break the electrical circuit. Based on interview at the time of observation, the Maintenance Director agreed the receptacle in the north hall Diet Kitchen was not properly GFCI protected. This finding was reviewed with the Administrator, Assistant Administrator, and Maintenance Director during the exit conference. 3.1-19(b)			

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K 0712 SS=F 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 audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to provide complete fire drill documentation for 3 of 12 fire drills performed during the past 12 month period. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 01/09/24 between 9:30 a.m. and 1:00 p.m. with the Maintenance Director present, the documented fire drill reports performed on 01/30/23 (second shift of the first quarter), 02/28/23 (third shift of the first quarter), and 09/29/23 (first shift of the third quarter) did not include the times the fire drills were performed. Based on interview at the time of record review, the Maintenance Director confirmed the lack of recorded times the fire drills were performed for the previously mentioned fire drill reports. This finding was reviewed with the Administrator, Assistant Administrator, and Maintenance Director during the exit conference.	K 0712	=”” span=”” no=”” residents=”” were=”” affected.<=””>Corrective actions taken: No residents were affected. =”” span=”” no=”” residents=”” were=”” affected.<=””> All others with potential to be affected: On 1-10-2024 the Assistant Administrator in serviced the Maintenance Supervisor/designee on the requirement that monthly fire drills must be completed and documentation (including but not limited to date and time) retained in the LSC Binder to meet set standards. Measures to prevent reoccurrence: Maintenance Supervisor will conduct monthly fire drills and place completed documentation in the facility's LSC Binder as a part of the facility's Emergency Preparedness Program. If any issues are	02/23/2024

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	3-1.19(b) 3.1-51(c)		discovered, they will be addressed and resolved immediately. The maintenance supervisor will review with the Administrator the fire drill reports. The Administrator will monitor adherence to the fire drill schedule and validate the Emergency Preparedness documentation in place. Monitoring corrective action: The fire drill report will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. The fire drill reports will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting every month for 6 months. The audit will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. ="" p="">	
K 0761 SS=F				

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Bldg. 01	Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 1 of 1 oxygen room fire door assembly 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 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	K 0761	=" " span=" ">Corrective actions taken: The door inspection of the oxygen door was completed by the maintenance supervisor/designee on 1-12-2024 according to the requirements. (See attachment D) =" " span=" "> All others with potential to be affected: No residents, staff, or visitors were affected by the deficiency. Measures to prevent reoccurrence: The facility maintenance supervisor/designee has been in-serviced by the Assistant Administrator that all 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. A note on the required annual inspection of the fire door assemblies has been added to the monthly fire door operation testing checklist. (See Fire Door inspection checklist) The month of March is highlighted indicating it is the month by which the annual door inspection must be completed each year. Monitoring corrective action: The Maintenance Director or his designee will review the door inspection documentation annually to ensure the door inspections have been completed and properly documented. The completed documents by the Maintenance Supervisor/designee to the	02/23/2024

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	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 01/09/24 between 9:30 a.m. and 1:00 p.m. with the Maintenance Director present, the facility was unable to provide documentation for an annual inspection of the oxygen transfilling room fire door assembly. Based on interview at the time of record review, the Maintenance Director said there was no documentation of an annual inspection of the oxygen transfilling room fire door assembly. Based on observations during a tour of the facility with the Maintenance Director between 1:00 p.m. and 3:00 p.m., there was one oxygen transfilling room fire door assembly noted in the facility. This finding was reviewed with the Administrator, Assistant Administrator, and Maintenance Director during the exit conference. 3.1-19(b)		Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting every month for 6 months. The audit will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. ="" p="">	

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K 0914 SS=F 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 complete documentation was available for all nonhospital-grade electrical receptacles in all resident room locations tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care	K 0914	=”” spancorrective=”” taken:=”” the=”” remaining=”” annual=”” nonhospital=”” grade=”” electrical=”” outlet=”” testing=”” was=”” completed=”” on=”” 1-15-2024=”” for=”” all=”” missing=”” resident=”” rooms=”” year=”” 2023=”” (see=”” attached=”” copies).=”” <=”” p=””> =”” span	02/23/2024

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	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 01/09/24 between 9:30 a.m. and 1:00 p.m. with the Maintenance Director present, there was documentation available of an annual resident room receptacle test for non hospital-grade receptacles for the past 12 month period, however, only 26 of 64 resident room receptacles were documented as having been inspected/tested during the past 12 month period. Based on interview at the time of record review, the Maintenance Director said electrical receptacles in resident rooms were not hospital-grade receptacles as far as he knew. Based on observations on 01/09/24 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, there were at least six to eight electrical receptacles in each resident room. This finding was reviewed with the Administrator, Assistant Administrator, and Maintenance Director during the exit conference. 3.1-19(b)		All others with potential to be affected: Annual nonhospital grade electrical outlet testing to be completed facility wide for all non-hospital grade electrical outlets for the year 2024 will be conducted within the first quarter. Our North Unit outlet testing was completed 1-24-2024 (see attached copies). West and East Unit will be completed by 2-23-2024 Measures to prevent reoccurrence: Maintenance Supervisor/designee will ensure all nonhospital grade electrical outlet testing is completed within the first quarter and documentation will be kept in the facility's LSC Binder as a part of the facility's Emergency Preparedness Program. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the documentation of annual receptacle testing. The Administrator will monitor adherence to the receptacle testing and validate the Emergency Preparedness documentation is in place every first quarter for consistency. Monitoring corrective action: The receptacle testing report will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly	

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			Quality Assurance/Performance Improvement (QA/PI) meeting every month for 6 months. The audit will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. ="" p="">	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder			

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	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 maintain a complete written record of monthly generator load testing for 1 of 1 generator during 2 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly	K 0918	Corrective actions taken: On 1/25/2024 the Assistant Administrator in-serviced the Maintenance Supervisor/designee on the requirement that monthly load testing of the emergency generator must be completed, and documentation retained in the LSC Binder to meet set standards. On 1/25/2024 the Assistant Administrator in-serviced the Maintenance Supervisor/designee on the requirement that weekly testing for the generator must be conducted every week and documentation retained in the LSC Binder to meet set standards. The facilities certified generator company was contacted and visited our facility on 1/29/2024 at 8am to complete training on the weekly testing and inspection and the monthly load testing of the emergency generator with the Maintenance Director, Maintenance Assistant and Assistant Administrator one time	02/23/2024

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	maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection and testing reports on 01/09/24 between 9:30 a.m. and 1:00 p.m. with the Maintenance Director present, there was no monthly generator load test documentation available for October and November of 2023 for the emergency generator, furthermore, there was monthly generator load test documentation for May and December of 2023, however, there was no date recorded for each of those two months. Based on interview at the time of record review, the Maintenance Director said the emergency generator runs a full load automatically every week, but, confirmed there was no emergency generator load test documentation for October and November of 2023, and no recorded date of the load tests during May and December of 2023. This finding was reviewed with the Administrator, Assistant Administrator, and Maintenance Director during the exit conference. 3.1-19(b)		to further educate. All others with potential to be affected: All residents, staff and visitors could be affected but none were. The facility has only one emergency generator. Measures to prevent reoccurrence: Maintenance Supervisor/Designee will inspect and test the emergency generator weekly and perform monthly load testing as required and retain documentation of those tests and inspections in the facility's LSC Binder as a part of the facilities Preventive Maintenance Program and document those inspection results as appropriate (see attachment A). If any issues are discovered, the will be address and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. The Administrator/designee will monitor adherence to the preventative maintenance schedule and validate the preventive maintenance documentation in place via a Life Safety Code checklist. Monitoring corrective action: The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the	

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			inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting every month for 6 months. The audit will be reviewed by the QA/PI committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulator requirements.	