STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155226	A. BUILDING -- B. WING	04/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(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: 04/04/23 Facility Number: 000131 Provider Number: 155226 AIM Number: 100274910 At this Emergency Preparedness survey, North Capitol Nursing & Rehabilitation Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 123 certified beds. At the time of the survey, the census was 65. Quality Review completed on 04/11/23 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
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)			

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

Roland Mann | Executive Director | 05/23/2023

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

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	reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October			

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	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, observation, and interview; the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff, and visitors. Findings include: a. Based on review of Direct Supply TELS Logbook Documentation "Emergency Generators: Test Generator under load" documentation for the most recent twelve-month period with the Executive Director and the Director of Maintenance during record review from 8:50 a.m. to 11:50 a.m. on 04/04/23, monthly load testing documentation for the facility's diesel fired emergency generator for the four-month period of June 2023 through September 2023 was not available for review. Based on interview at the time of record review, the Director of Maintenance stated there was staff turnover for the Director Of Maintenance position last year and agreed monthly load testing documentation for the four-month period of June 2023 through September 2023 was not available for review. b. Based on record review with the Executive Director and the Director of Maintenance from 8:50 a.m. to 11:50 a.m. on 04/04/23, thirty-six-month period emergency generator testing	E 0041	**1. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Documentation is now in place. no further issues identified. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents can have the potential to be affected by this deficient practice. **3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur**? Maintenance director or designee will audit weekly to ensure generators are checked with and without load on schedule. completed. Audits will be conducted each week x 4, then monthly x4, then as needed if no trends are identified.	04/28/2023

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	documentation for four continuous hours for the facility's diesel fuel fired emergency generator was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility has one diesel fuel fired emergency generator and agreed documentation of supplemental load testing for four hours within the most recent three-year period was not available for review at the time of the survey. Based on observations with the Executive Director and the Director of Maintenance during a tour of the facility from 12:25 p.m. to 3:15 p.m. on 04/04/23, the facility has one diesel fired emergency generator located outside the building on the west side of the property. Manufacturer's documentation affixed to the nameplate of the emergency generator indicated it was rated at 300 kW. c. Based on review of Direct Supply TELS Logbook Documentation "Conduct a 30-second functional test" for the most recent twelve-month period with the Executive Director and the Director of Maintenance during record review from 8:50 a.m. to 11:50 a.m. on 04/04/23, monthly functional testing documentation for the facility's battery-operated lights for the three-month period of June 2023 through August 2023 was not available for review. Based on interview at the time of record review, the Director of Maintenance stated there was staff turnover for the Director of Maintenance position last year and agreed monthly battery-operated light testing documentation for the three-month period of June 2023 through August 2023 was not available for review. Based on observations with the Executive Director and the Director of Maintenance during a tour of the facility from 12:25 p.m. to 3:15 p.m. on 04/04/23, two battery operated lights were noted for the facility. The light locations were in the		**4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Emergency power supply QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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	weatherproof shell for the facility's emergency generator and inside the room housing the automatic transfer switches for the facility's emergency generator. Each light illuminated when its respective test button was pushed. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference.			
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/04/23 Facility Number: 000131 Provider Number: 155226 AIM Number: 100274910 At this Life Safety Code survey, North Capitol Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies. This four-story facility was determined to be of Type II (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a total of 15 vent	K 0000		

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	unit beds. Vent unit beds are located on the third floor in Rooms 319 through 326. The facility has a capacity of 123 and had a census of 65 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which was not sprinklered. Quality Review completed on 04/11/23			
K 0161 SS=F Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed			

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	non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. Based on observation and interview, the facility failed to ensure the building construction type was a permitted type as listed in Table 19.1.6.1. Table 19.1.6.1 requires a sprinklered building, four or more stories in height, to be Type II (222), Type I (332) or Type I (442). This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Executive Director and the Director of Maintenance during a tour of the facility from 12:25 p.m. to 3:15 p.m. on 04/04/23, this four story sprinklered building was constructed of unprotected steel and was determined to be Type II (000) construction. The interior load bearing wall above the suspended ceiling above the north stairwell door by Room 203, Room 302 and Room 402 was unprotected. This results in a construction type classification of Type II (000). Based on interview at the time of the observations, the Executive Director and the Director of Maintenance stated there was no change in the construction type since the most recent Life Safety Code survey and agreed interior load bearing walls consisted of unprotected steel.	K 0161	1. On 4/28/2023 a new FSES was completed using NFPA 101A, Guide on Alternative Approaches to Life Safety, 2001 Edition, post correction of items other than noted on K161. The 4/28/2023 FSES demonstrates the level of fire safety is equivalent to that prescribed by NFPA 101, Life Safety Code for Healthcare Occupancies. (see attached FSES worksheet) 2. All residents have the potential to be affected. The 4/28/2023 FSES demonstrates the level of fire safety is equivalent to that prescribed by NFPA 101, Life Safety Code for Healthcare Occupancies. (see attached FSES worksheet) 3. Following corrective actions to all items with the exception of K161, noted on the CMS-2567, the facility completed a FSES worksheet on 4/28/2023 which	04/28/2023

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	These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b)		resulted in all items in Worksheet 4.7.9 checked as "Yes" and all items in Worksheet 4.7.10 being identified as "Met". The 4/28/2023 FSES demonstrates the level of fire safety is equivalent to that prescribed by NFPA 101, Life Safety Code for Healthcare Occupancies. 4. Executive Director will ensure a FSES worksheet is completed annually and the facility meets level of fire safety equivalent to NFPA 101 . 5. Compliance date: 4/28/2023	
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			

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	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 Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of over 12 hazardous areas such as soiled linen and trash collection rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff, and visitors in the vicinity of the soiled linen and trash collection room by Room 325 on the third floor. Findings include: Based on observations with the Executive Director and the Director of Maintenance during a tour of the facility from 12:25 p.m. to 3:15 p.m. on 04/04/23, the latching mechanism for the corridor door to the soiled linen and trash collection room by Room 325 on the third floor was taped down which prevented the door from latching into the door frame. The door was equipped with a self-closing device and self-closed and latched into the door frame when the tape was removed by the Director of Maintenance. The room contained seven partially filled 32-gallon soiled linen and trash carts. Based on interview at the time of the observations, the Director of	K 0321	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All doors on vent unit were secured properly by maintenance staff. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** **This deficient could affect are residents, staff and visitors on the vent unit.** **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Vent unit staff in serviced on not	05/02/2023

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	Maintenance agreed taping down the latching mechanism for the corridor door to the room prevented the door from self-closing and latching into the door frame. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b)		propping open and taping door latches. In addition education will be provided to all staff regarding improperly securing door. ED/Designee to round 5x weekly x 30 days to ensure no doors are improperly secured. If no trends identified, rounds will continue 2 x per week times 30 days , the 1 x per week times 30 days. ="" b="">"> **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** ·Door qapi Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance **="" b="">"**	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the			

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	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 record review, observation, and interview; the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of the sprinkler system inspection contractor's "Form for Inspection,	K 0353	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The Sprinkler head in the laundry room behind the dryer was cleaned and lint was removed. 4-10-2023 Purchase agreement to address remaining sprinkler heads and piping was approved . This will also address the piping areas located on the second, third floor and other areas throughout facility as identified. Repairs to be begin Monday May 22, 2023. ="" bthe sprinkler="">
="" span="">

2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? | 05/29/2023 |

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	Testing and Maintenance of Wet Pipe Fire Sprinkler Systems" documentation dated 03/22/22 with the Executive Director and the Director of Maintenance during record review from 8:50 a.m. to 11:50 a.m. on 04/04/23, deficiencies were noted during the annual inspection of the facility's wet sprinkler system under Section II.A.4 of the 03/22/22 inspection report. The "Deficiency Summary" section of the 03/22/22 inspection report indicated the spare sprinkler box did not have the proper number and type of spare sprinklers, sprinkler locations on the second and third floor need to be recut in length and sprinkler heads and piping at various locations throughout the facility were corroded and need replaced. In addition, review of the sprinkler system inspection contractor's "Form for Inspection, Testing and Maintenance of Wet Pipe Fire Sprinkler Systems" documentation dated 03/13/23, deficiencies were noted during the annual inspection of the facility's wet sprinkler system under Section II.A.4 of the 03/13/23 inspection report. The "Deficiency Summary" section of the 03/13/23 inspection report indicated numerous sprinkler locations throughout the facility were not "free of foreign materials including paint". The "Deficiency Summary" section of the 03/13/23 inspection report also stated, "First floor mop sink riser-(2) gauges need replace but has bad 1/4-inch 3-way globe valve needs replaced at same time". Based on interview at the time of record review, the Executive Director stated the deficiencies noted by the inspection contractor during the 03/22/22 and 03/13/23 annual inspections have not been corrected and provided "Purchase Agreement" documentation dated 03/13/23 for "Sprinkler Head Replacement and Service" by the inspection contractor. The "Purchase		**All residents and staff have the potential to be affected by this deficient practice.** **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not reoccur?** Maintenance director to be in serviced on Sprinkler Head compliance. Routine audits will be completed to ensure that all sprinkler heads remain clean in compliance. Audits will be conducted x 5 business days per week for 30 days, then 2 x weekly for 30 days, then 1 x weekly for 30 days. If no trends identified the audits will continue on an as needed basis. ="" span="">"> **4. How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place?** Sprinkler qapi tool will be utilized weekly x4 weeks, the monthly x 6 months, and quarterly thereafter for one year with results reported to the QAPI committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	155226	A. BUILDING 01 B. WING	04/04/2023

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	Agreement" documentation was approved by the facility 03/15/23 but the facility is awaiting approval of the expenses by the Corporate Office. Based on observations with the Executive Director and the Director of Maintenance during a tour of the facility from 12:25 p.m. to 3:15 p.m. on 04/04/23, the sprinkler location behind the dryers in the first-floor laundry was loaded with lint. This sprinkler was not included in the "Deficiency Summary" section of the 03/22/22 and 03/13/23 annual inspection reports. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b)		=”” span=””> =”” span=””> =”” span=””> =”” b=””> =”” b=””> =”” b=”” >	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. 1. Based on observation and interview, the facility failed to ensure openings through 1 of 4 ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states	K 0372	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	04/28/2023

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	penetrations for cables, conduits, pipes, and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect over 10 residents, staff, and visitors in the vicinity of Room 313 on the third floor. Findings include: Based on observations with the Executive Director and the Director of Maintenance during a tour of the facility from 12:25 p.m. to 3:15 p.m. on 04/04/23, a ten inch by ten-inch hole was noted in the ceiling of resident sleeping Room 313 on the third floor. The hole in the ceiling was near the center of the room and an open metal grate was affixed to the ceiling over the hole. The ceiling consisted of one layer of 5/8ths inch thick drywall. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned opening did not ensure the ceiling smoke barrier was protected to maintain the fire resistance rating of the smoke barrier. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 2 smoke barrier walls on the		· The ten inch by ten inch hole has been repaired in 313. 4-17-2023 · 3 inch hole near room 306 has been repaired. 4-17-2023 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** **Residents, staff and visitors in the vicinity of room 306 and 313 have the potential to be affected by this deficient practice.** **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** **An audit has been completed to identify any openings that require fire rated closures or ceiling repairs** **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·/b>	

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	third floor were protected to maintain the fire resistance rating of the smoke barrier wall. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect over 20 residents, staff, and visitors near the vicinity of the smoke barrier wall by Room 306 on the third floor. Findings include: Based on observations with the Executive Director and the Director of Maintenance during a tour of the facility from 12:25 p.m. to 3:15 p.m. on 04/04/23, a three inch by one inch hole was noted in the smoke barrier wall above the suspended ceiling above the corridor door set by Room 306 on the third floor for the passage of cables through the wall. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned opening in the third-floor smoke barrier wall was not firestopped to maintain the fire resistance rating of the smoke barrier wall. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b)			
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.			

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	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 documentation of a fire drill conducted on the second and third shift for 2 of 4 quarters. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Fire Drills" with the Executive Director and the Director of Maintenance during record review from 8:50 a.m. to 11:50 a.m. on 04/04/23, documentation of a fire drill conducted on the second and third shift in the second quarter (April, May, June) 2022 and the third quarter (July, August, September) 2022 was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility operates three shifts per day, there was staff turnover for the Director of Maintenance position last year and the Director of Maintenance agreed documentation of a fire drill conducted on the aforementioned shifts and quarters in 2022 was not available for review. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b)	K 0712	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Fire Drills have been reviewed and no issues were identified outside of the identified dates **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents and visitors have the potential to be affected by this deficient practice. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ED/Designee to conduct an Inservice to maintenance regarding completion of fire drills and frequency of occurrence. The ED or designee will make review fire drills with maintenance director to ensure this practice does not recur. Review will occur every business day x 4 weeks,	05/02/2023

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			then 2 business days per week x 4 weeks, then as needed if no trends. **4. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·Fire Drill QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	
K 0761 SS=F Bldg. 01	Based on record review, observation, and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance 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	K 0761	**1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** **Facility Fire door inspection was scheduled for completion. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?The deficient practice could affect all residents, staff and**	05/02/2023

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	NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the fully 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,		**visitors. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?The Maintenance Director has been trained to complete testing of the fire doors. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The Maintenance Director/designee will maintain a log to ensure annual compliance of the fire door testing is completed. All results will be submitted to the Quality Assurance Committee.**	

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	staff, and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Fire-Smoke Doors (Opening Protectives): Annual Fire/Smoke Door Inspections" dated October 2022 with the Executive Director and the Director of Maintenance during record review from 8:50 a.m. to 11:50 a.m. on 04/04/23, annual fire door inspection documentation for the facility within the most recent twelve-month period did not include fire door locations on the fourth floor. Based on interview at the time of record review, the Director of Maintenance stated the fourth floor is not currently occupied but agreed annual fire door inspection documentation for the facility within the most recent twelve-month period did not include fire doors on the fourth floor. Based on observations with the Executive Director and the Director of Maintenance during a tour of the facility from 12:25 p.m. to 3:15 p.m. on 04/04/23, the fourth-floor stairwell door by Room 402 and by Room 428 each had a 90-minute fire resistance rating label affixed to the hinge side of the door. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b)			
K 0914 SS=E Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general			

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	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 record review, observation, and interview; the facility failed to ensure nonhospital-grade electrical receptacles that failed annual testing in 6 of over 50 resident rooms were replaced with hospital-grade receptacles. NFPA 70, The National Electrical Code, 2011 Edition, at Article 517.18(B) states each patient bed location shall be provided with a minimum of four receptacles. They shall be permitted to be of the single, duplex, or quadruplex type, or any combination of the three. All receptacles, whether four or more, shall be listed "hospital grade" and so identified. It is not intended that there be a total, immediate replacement of existing non-hospital grade receptacles. It is intended, however, that non-hospital grade receptacles be replaced with hospital grade receptacles upon modification of use, renovation, or as existing receptacles need replacement. This deficient	K 0914	**1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** **All testing of the electrical outlet receptacles in resident rooms have been completed. All failed receptacles have been replaced in rooms 403,406,407,411, therapy room and 425 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?No residents reside on this floor. No residents have the potential**	05/02/2023

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	practice could affect over 10 residents. Findings include: Based on review of "Receptacle Testing" documentation dated 04/22/22 with the Executive Director and the Director of Maintenance during record review from 8:50 a.m. to 11:50 a.m. on 04/04/23, select electrical receptacles in resident sleeping Room 403, 406, 407, 411, 425 and in the Therapy Room on the fourth-floor failed inspection and testing and were listed as "Replace Outlet" for "If Fail: Corrective Action". Based on interview at the time of record review, the Executive Director and the Director of Maintenance stated he was unsure if the receptacles which failed the 04/22/22 annual inspection were replaced with hospital-grade receptacles. Based on observations with the Executive Director and the Director of Maintenance during a tour of the facility from 12:25 p.m. to 3:15 p.m. on 04/04/23, all receptacle locations in Room 403, 406, 407 and 425 were not hospital grade. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b)		**to be affected at this time. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?The Maintenance Director/designee will maintain an audit tool to ensure that testing for all resident room receptacle outlets has been completed annually.4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The Maintenance Director/designee will ensure the annual monitoring/audit tool for the testing of all resident room receptacles have been completed. This will be ongoing, and all results will be presented bi-annually to the Quality Assurance Committee.**	
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			

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	annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1. Based on record review and interview, the facility failed to document emergency generator monthly load testing for 4 months of the most recent 12-month period to meet the requirements of NFPA 110, Standard for Emergency and Standby Powers Systems, 2010 Edition, Chapter 8.4.2. Section 8.4.2 states diesel generator sets shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust	K 0918	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** **All twelve month load testing has been reviewed and are currently up to date on a go forward basis. 36 month load testing has been scheduled. Documentation for the 36**	05/03/2023

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	gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Generators: Test Generator under load" documentation for the most recent twelve-month period with the Executive Director and the Director of Maintenance during record review from 8:50 a.m. to 11:50 a.m. on 04/04/23, monthly load testing documentation for the facility's diesel fired emergency generator for the four-month period of June 2023 through September 2023 was not available for review. Based on interview at the time of record review, the Director of Maintenance stated there was staff turnover for the Director Of Maintenance position last year and agreed monthly load testing documentation for the four-month period of June 2023 through September 2023 was not available for review. These findings were reviewed with the Executive Director and the Director of Maintenance during		**month load testing is now available in the log book for review.** **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents and visitors have the potential to be affected by this deficient practice** **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · ED/Designee to conduct an Inservice to maintenance regarding completion of emergency generator load testing. **4. How will this be monitored?** The ED or designee will make review emergency generator load testing with the maintenance director to ensure this practice does not recur. Review will occur every business day x 4 weeks, then 2 business days per week x 4 weeks, then as needed if no trends. Review will be brought to qapi for 6month then on an as needed basis if no trends identified	

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	155226	A. BUILDING 01 B. WING	04/04/2023

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	the exit conference. 3.1-19(b) 2. Based on record review, observation, and interview; the facility failed to document 36-month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Executive Director and the Director of Maintenance from 8:50 a.m. to 11:50 a.m. on 04/04/23, thirty-six-month period emergency generator testing documentation for four continuous hours for the facility's diesel fuel fired emergency generator was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility has one diesel fuel fired			

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	emergency generator and agreed documentation of supplemental load testing for four hours within the most recent three-year period was not available for review at the time of the survey. Based on observations with the Executive Director and the Director of Maintenance during a tour of the facility from 12:25 p.m. to 3:15 p.m. on 04/04/23, the facility has one diesel fired emergency generator located outside the building on the west side of the property. Manufacturer's documentation affixed to the nameplate of the emergency generator indicated it was rated at 300 kW. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b) 3. Based on record review, observation, and interview; the facility failed to ensure 2 of 2 emergency task generator battery backup lights was maintained. NFPA 110, 2010 Edition at section 7.3.1 requires the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access. 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, staff, and visitors.			

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	Findings include: Based on review of Direct Supply TELS Logbook Documentation "Conduct a 30-second functional test" for the most recent twelve-month period with the Executive Director and the Director of Maintenance during record review from 8:50 a.m. to 11:50 a.m. on 04/04/23, monthly functional testing documentation for the facility's battery-operated lights for the three-month period of June 2023 through August 2023 was not available for review. Based on interview at the time of record review, the Director of Maintenance stated there was staff turnover for the Director of Maintenance position last year and agreed monthly battery-operated light testing documentation for the three-month period of June 2023 through August 2023 was not available for review. Based on observations with the Executive Director and the Director of Maintenance during a tour of the facility from 12:25 p.m. to 3:15 p.m. on 04/04/23, two battery operated lights were noted for the facility. The light locations were in the weatherproof shell for the facility's emergency generator and inside the room housing the automatic transfer switches for the facility's emergency generator. Each light illuminated when its respective test button was pushed. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b)			
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container			

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	Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			

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	Based on observation and interview, the facility failed to ensure 1 of 1 indoor oxygen storage areas was in accordance with NFPA 99 Health Care Facilities Code. NFPA 99, 2012 Edition, Section 11.3.1 states storage for nonflammable gases equal to or greater than 3000 cubic feet shall comply with 5.1.3.3.2 and 5.1.3.3.3. Section 5.1.3.3.2 states, if indoors, storage locations of positive-pressure gases shall be constructed and use interior finishes of noncombustible or limited combustible materials such that all walls, floor, ceilings, and doors are of minimum 1-hour fire resistant rating. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room inside the dining room on the third floor. Findings include: Based on observations with the Executive Director and the Director of Maintenance during a tour of the facility from 12:25 p.m. to 3:15 p.m. on 04/04/23, two separate one inch in diameter holes were noted in the ceiling of the oxygen storage and transfilling room which is inside the dining room on the third floor. Six liquid oxygen containers and eleven 'E' type oxygen cylinders were stored in the room. Based on interview at the time of the observations, the Director of Maintenance agreed the oxygen storage and transfilling room was not constructed of a minimum 1-hour fire resistant rating. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b)	K 0923	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** **Both 1inch diatmeter holes have been filled.** **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** **All residents and visitors have the potential to be affected who visit or reside on that unit.** **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · ED/Designee to conduct an Inservice to maintenance director regarding reparing penetrations in the oxygen room **4. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·Oxygen room qapi Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director	05/02/2023

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			·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	