STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155510	A. BUILDING -- B. WING	10/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CENTURY VILLA HEALTH CARE	705 N MERIDIAN ST GREENTOWN, IN 46936

(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: 10/31/22 Facility Number: 000549 Provider Number: 155510 AIM Number: 100267470 At this Emergency Preparedness survey, Century Villa 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 84 certified beds. At the time of the survey, the census was 68. Quality Review completed on 11/01/22	E 0000	This Plan of Correction constitutes Century Villa Health Care and Rehabilitation's written allegation of compliance for the alleged deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law. Century Villa Health Care and Rehabilitation respectfully requests a desk review for this Plan of Correction.	
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			

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

Michael Gerig | Executive Director | 11/23/2022

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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	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 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.			

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	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 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and			

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	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). This deficient practice could affect all occupants. Findings include: During record review with the Maintenance Director and Environmental Services Director on 10/31/22 between 10:00 a.m. and 12:45 p.m., the facility provided documentation for testing of the emergency generator, however, could not provide documentation of a three-year 4-hour test. This was confirmed by the Maintenance Director, who stated he was unaware of the requirement and verified with the contractor during the survey the need for the aforementioned test. This deficiency was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director, Environmental Services Director, Executive Director and a Corporate Representative all present.	E 0041	EO41 Emergency and Standby Power systems The corrective action is that the generator will have a 4-hour running test every 3 years per regulation. All residents of the facility could be affected by the deficient practice. The measure for correcting the deficiency will be a 4 hour documented run of the generator per regulation with photo evidence on hour meter. This corrective action will take place 11-15-22 and documentation is placed in EOP manual as well as Maintenance records. Maintenance dept will continue to insure generator is run at appropriate times, per regulation, and will keep a running record of all run functions on a monthly basis.	11/15/2022
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: 10/31/22	K 0000	This Plan of Correction constitutes Century Villa Health Care and Rehabilitation's written allegation of compliance for the alleged deficiencies cited. Submission of this Plan of Correction is not an	

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	Facility Number: 000549 Provider Number: 155510 AIM Number: 100267470 At this Life Safety Code survey, Century Villa Health Care was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA)101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of type V (111) construction and was fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard-wired smoke detectors in all resident sleeping rooms. The healthcare portion of the facility has a capacity of 84 and had a census of 68 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 11/01/22		admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law. Century Villa Health Care and Rehabilitation respectfully requests a desk review for this Plan of Correction.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the			

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	clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS			

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	Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure all exterior exit doors were readily accessible and able to open on first try. This deficient practice could affect all occupants in the facility. Findings include: Based on a facility tour and interview with the Maintenance Director and Environmental Services Director on 10/31/22 between 12:45 p.m. and 3:15 p.m., the Dining Room double glass exit doors would not open easily on the first try when tested. The Surveyor, then the Maintenance Director tried to open the door, and the Maintenance Director was able, after considerable effort to open the double exit doors. The Maintenance Director stated that the wall to the aforementioned double exit door set was a load wall and that this condition was challenging to correct. This deficiency was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director, Environmental Services Director, Executive Director and a Corporate Representative	K 0222	K222 Egress Doors The corrective measure for the doors not opening easily will be corrected by sanding the finish of the door jams and adjusting the hinges, freeing up the movement of said doors. All residents and staff of the facility in this dining area that tried to use the doors prior could be affected. Maintenance team corrected the sticking doors by sanding the finish and adjusting the hinges insuring they move freely at every attempt to open. This corrective action took place on 11-15-22 and documentation will be placed in maintenance record and this survey report, and will be maintained and checked monthly to insure egress is available from this set of doors and placed in the maintenance record.	11/15/2022

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	all present. 3.1-19(b)			
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure the courtyard doors to the outside of the facility were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 25 residents. Findings include: Based on a facility tour and interview with the Maintenance Director and Environmental Services Director on 10/31/22 between 12:45 p.m. and 3:15 p.m., in the Activities area, the door to the outside courtyard was not an exit door and the door was not posted with a "NO EXIT" sign. Based on interview at the time of the observations, the Environmental Services Director stated the	K 0293	K 293 Exit Signage The corrective action for this sign, is for it to prominently hung on door, signifying that it is NOT an emergency exit. All residents and staff could be affected at time of emergency without proper signage being displayed. The corrective action for hanging new signage on this door took place on 11-14-22. Maintenance group will maintain that the sign is hung and in place in course of their weekly duties and will make part of the monthly maintenance record.	11/14/2022

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	courtyard is not an exit to the public way and acknowledged the courtyard door did not have a "NO EXIT" but she believed there once was a no exit sign at this location which had been removed and not replaced. This deficiency was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director, Environmental Services Director, Executive Director and a Corporate Representative all present. 3.1-19(b)			
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			

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	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 2 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 10 residents, as well as staff and visitors. Findings include: Based on a facility tour and interview with the Maintenance Director and Environmental Services Director on 10/31/22 between 12:45 p.m. and 3:15 p.m., the following was noted: A) The Wheel Chair Storage room on the 100 Hall, contained a number of combustible items, such as, 3 beds, 6 large cardboard boxes, 6 chairs and several tables. The corridor door to this room was not equipped with a self-closing device. B) The Library contained 4 large shelves filled with combustible books. The corridor door to this room was not equipped with a self-closing device. This deficiency was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director, Environmental Services Director, Executive Director and a Corporate Representative all present.	K 0321	K 321 Hazardous Areas-Enclosures Two areas that have combustible materials did not have door enclosures. This deficient practice could affect more than 10 residents, as well as staff and visitors in case of fire emergency. The area on 110 hall and library are affected and will have door enclosures attached to door, resulting in automatic closure when not in use. This corrective action took place 11-14-22 and door enclosures were put in place for the 100-hall room and library. Maintenance will maintain the proper working order and check monthly. This will be placed in maintenance record.	11/14/2022

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	3.1-19(b)			
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction in in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff and up to 12 residents. Findings include: Based on a facility tour and interview with the	K 0351	K351 Sprinkler System-Installation The escutcheons in 200 hall bathing room and kitchen closet were missing upon life safety inspection on 2 sprinkler heads. Staff and up to 12 residents could be affected by this deficiency. The escutcheons were put in place by Safecare on 11-8-22 and cover the hole around sprinkler head. Corrected on 11-8-22 by Safecare and to be maintained going	11/08/2022

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	Maintenance Director and Environmental Services Director on 10/31/22 between 12:45 p.m. and 3:15 p.m., (1) in the Assisted Bathing room on the 200 Hall and (2) in the kitchen closet / furnace room sprinkler heads were missing escutcheons and did not completely cover the hole around the sprinkler. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned areas were missing escutcheons and stated the contractors must have forgot to reinstall them. This deficiency was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director, Environmental Services Director, Executive Director and a Corporate Representative all present. 3.1-19(b)		forward by Century Villa maintenance team if they need repair on a monthly basis and recorded in maintenance record.	
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. Based on observation and interview, the facility failed to ensure all smoke barriers walls were	K 0372	K372 Subdivision of Building Spaces-Smoke Barrier	11/08/2022

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(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
	protected to maintain the smoke resistance of each smoke barrier. 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. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 16 residents and staff. Findings include: Based on a facility tour and interview with the Maintenance Director and Environmental Services Director on 10/31/22 between 12:45 p.m. and 3:15 p.m., the fire wall above the drop ceiling near the service hall entrance had two 1 inch holes containing Category 5 cable which were not completely sealed and could resist the passage of smoke. This deficiency was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director, Environmental Services Director, Executive Director and a Corporate Representative all present. 3.1-19(b)		The corrective action for two 1-inch holes containing A Category 5 cable in fire wall above drop ceiling will be caulked with fire rated sealant. Staff and at least 16 residents could be affected by a failure in a fire/smoke wall. The caulking of the 1-inch hole in the fire wall above the drop ceiling in the service hall was completed on 11-8-22. This is a 1-time fix and was documented with photos as complete and air and light tight. Maintenance will make this part of monthly checks and insure that it remains intact and complete, and placed in maintenance record.	

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	155510	A. BUILDING 01 B. WING	10/31/2022

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K 0511 SS=E 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 were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (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	K 0511	K511 Utilities-Gas and Electric The corrective action for installing a GFCI receptacle outlet in the Men's Bathroom near central nurse station will correct deficiency. All staff and up to one resident could be affected by this deficient practice. The GFCI receptacle was installed on 10-31-22 by maintenance to correct outlet within 3 feet of a water source. This is a 1-time fix and was documented with photos to show completion. Maintenance will check monthly to insure the GFCI receptacle is in working order and placed in maintenance record.	10/31/2022

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	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 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 staff and up to 1 resident while using the common restroom. Findings include: Based on a facility tour and interview with the Maintenance Director and Environmental Services			

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	Director on 10/31/22 between 12:45 p.m. and 3:15 p.m., the Men's Restroom near the central main nurses' station had an electric receptacle located within 3 feet of the hand washing sink which was not provided with ground fault circuit interruption (GFCI). The Maintenance Director at the time of observation stated he did not believe the receptacle was on a GFCI circuit. This deficiency was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director, Environmental Services Director, Executive Director and a Corporate Representative all present. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, 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			

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	personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: During record review with the Maintenance Director and Environmental Services Director on 10/31/22 between 10:00 a.m. and 12:45 p.m., the facility provided documentation for testing of the emergency generator, however, could not provide	K 0918	K918 Electrical Systems The corrective action is that the generator will have a 4-hour running test every 3 years. All residents of the facility could be affected by the deficient practice. The measure for correcting the deficiency will be a 4-hour documented run of the generator per regulation with photo evidence on hour meter. This corrective action will take place 11-15-22 and documentation is placed in the EOP manual and Maintenance records. Maintenance will insure that generator is run at appropriate times and will keep a record of all run functions on a monthly basis.	11/15/2022

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	documentation of a three-year 4 hour test. This was confirmed by the Maintenance Director, who stated he was unaware of the requirement and verified with the contractor during the survey the need for the aforementioned test. This deficiency was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director, Environmental Services Director, Executive Director and a Corporate Representative all present. 3.1-19(b)			