

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155855	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>--</u> B. WING <u> </u>	(X3) DATE SURVEY COMPLETED 08/15/2022
NAME OF PROVIDER OR SUPPLIER MCGIVNEY HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 2907 EAST SMOKY ROW CARMEL, IN 46033		
(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. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 08/15/22</p> <p>Facility Number: 000545 Provider Number: 155855 AIM Number: 100267350</p> <p>At this Emergency Preparedness survey, McGivney Health Care Center was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73</p> <p>The facility has 37 certified beds. At the time of the survey, the census was 32.</p> <p>Quality Review completed on 08/17/22</p>	E 0000		
E 0037 SS=C Bldg. --	<p>403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1)</p> <p>EP Training Program</p> <p>§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).</p> <p>*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475,</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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	<p>HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]</p> <p>(1) Training program. The [facility] must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. 			

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	<p>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. 			

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	<p>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.</p> <p>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. <p>*[For CORFs at §485.68(d):] (1) Training. The CORF must do all of the following:</p> <ul style="list-style-type: none"> (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. <p>(v) If the emergency preparedness policies</p>			

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	<p>and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. <p>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.</p> <p>Based on record review and interview, the facility</p>		E 0037	McGivney did the annual training
				09/06/2022

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E 0039 SS=C Bldg. --	<p>failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on records review and interview with the Maintenance Director on 08/15/22 between 9:45 a.m. and 11:45 a.m., there was documentation of a sheet for EPP training; but there was no documentation to show staff could demonstrate knowledge of the EPP. The EPP quiz section in the EPP binder contained only blank forms. Based on an interview at the time of records review, the Maintenance Director stated that no other documentation was available for review, the Maintenance Director had reached out to the Administrator during the survey but no other documentation had been provided.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director present at 2:15 p.m.</p> <p>403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2),</p>		<p>but maintenance failed to show the annual training in-service form therefore the deficiency was for facility failed to conduct annual training for EPP.</p> <p>All staff and residents have the potential to be affected by deficiency cited.</p> <p>McGivney will continue to do there annual training in June. Maintenance will be in charge of conducting and filing in-services.</p> <p>ED will continue to log the in-services in office.</p>	

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	<p>486.360(d)(2), 491.12(d)(2), 494.62(d)(2)</p> <p>EP Testing Requirements</p> <p>§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d) (2), §491.12(d)(2), §494.62(d)(2).</p> <p>*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <p>(i) Participate in a full-scale exercise that is community-based every 2 years; or</p> <p>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or</p> <p>(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2) (i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is</p>			

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

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	<p>discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:</p> <ul style="list-style-type: none"> (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: <ul style="list-style-type: none"> (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. 			

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	<p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]</p> <p>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p> <ul style="list-style-type: none"> (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: <ul style="list-style-type: none"> (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. 			

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	<p>*[For PACE at §460.84(d):]</p> <p>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:</p> <ul style="list-style-type: none"> (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. <ul style="list-style-type: none"> (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. <ul style="list-style-type: none"> (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. <p>*[For LTC Facilities at §483.73(d):]</p> <p>(2) The [LTC facility] must conduct exercises</p>			

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

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

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

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	<p>problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.</p> <p>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCl's and OPO's] emergency plan, as needed.</p> <p>*[RNCHIs at §403.748]:</p> <p>(d)(2) Testing. The RNHCl must conduct exercises to test the emergency plan. The RNHCl must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the RNHCl's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCl's emergency plan, as needed.</p> <p>Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p>	E 0039	<p>Facility failed to conduct exercises to test the EP at least twice a year.</p> <p>All residents and staff have the potential to be affected by this deficient practice.</p> <p>McGivney will continue to do our two table tops each year and log the education and scenarios.</p>	09/01/2022

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	<p>b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following:</p> <ul style="list-style-type: none"> a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. <p>(iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review and interview with the Maintenance Director on 08/15/22 between 9:45 a.m. and 11:45 a.m., the facility was able to provide documentation of its response to the COVID-19 Public Health Emergency, however, was unable to provide documentation of a second exercise of choice to test the emergency preparedness plan. Based on interview at the time of record review, the Maintenance Director agreed that documentation of a second exercise of choice was not available for review.</p>			CEO will continue to preside over the EPP and update continuously with the regulation and emergency order.	

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E 0041 SS=C Bldg. --	<p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director present at 2:15 p.m.</p> <p>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.</p> <p>§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.</p> <p>§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.</p> <p>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</p>			

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	<p>inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.</p> <p>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.</p> <p>*[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.</p> <p>(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.</p> <p>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.</p>			

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	<p>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.</p> <p>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.</p> <p>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.</p> <p>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.</p> <p>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.</p> <p>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.</p> <p>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.</p> <p>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.</p> <p>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.</p> <p>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.</p> <p>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..</p> <p>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.</p> <p>Findings include:</p> <p>Based on records review and interview with the Maintenance Director on 08/15/22 between 9:45 a.m. and 11:45 a.m., the facility provided documentation for testing of the emergency generator, however, could not provide documentation of a three-year 4-hour test. The</p>	E 0041	<p>E41</p> <p>1. The facility failed to do a 4 hour load test every 3 years and failed to document load percentage every week.</p> <p>2. All residents and staff have the potential to be affected by this deficient practice.</p> <p>3. McGivney scheduled the 4 hour load test 8/29/22. Evapar completed the test on 8/29/22.</p> <p>4. Facility Maintenance Director will monitor and schedule the Evapar test every 3 years.</p>	08/29/2022

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K 0000 Bldg. 01	<p>Maintenance Director also stated that he was not keeping a record of the percentage of load the emergency generator was under during his regular load tests. The Maintenance Director stated he was unaware of the requirement.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director present at 2:15 p.m.</p> <p>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).</p> <p>Survey Date: 08/15/22</p> <p>Facility Number: 000545 Provider Number: 155855 AIM Number: 100267350</p> <p>At this Life Safety Code survey, McGivney Health Care 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 and 410 IAC 16.2.</p> <p>This one-story facility with a basement was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, all areas open to the corridor and hard-wired smoke detectors in all resident sleeping rooms. The</p>		K 0000	

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K 0211 SS=E Bldg. 01	<p>basement was included in this survey. The basement, without 2 hour separation, has 8 apartment residences and at the time of this survey 3 of the apartments were occupied by the public. The facility has a capacity of 37 and had a census of 32 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for a detached storage building which was not sprinklered.</p> <p>Quality Review completed on 08/17/22</p> <p>NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 5 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects 20 residents.</p> <p>Findings include:</p> <p>Based on a facility tour and interview with the Maintenance Director on 08/15/22 between 11:45 a.m. and 2:00 p.m., in the main entrance lobby there were 12 large boxes containing reams of paper against the wall protruding into the corridor about two feet. Based on an interview at the time of observations, the Maintenance Director stated</p>	K 0211	<p>K211</p> <ol style="list-style-type: none"> The facility failed to ensure 1 of 5 corridor means of egresses were continuously maintained free of obstruction. All staff have the potential to be affected by this deficient practice. McGivney Maintenance removed the copy paper and educated the staff and delivery driver of proper destination for drop off. McGivney ED will monitor delivery drop offs. 	09/02/2022

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K 0232 SS=E Bldg. 01	<p>the boxes filled with paper were in the corridor and will be moved. The Maintenance Director is only in the building 3 days per week, and sometimes delivered items can back up.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director present at 2:15 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation, the facility failed to meet the clear width requirement for 1 of 5 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met:</p> <ul style="list-style-type: none"> (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by LSC 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. 	K 0232	<p>K232</p> <ol style="list-style-type: none"> 1. The facility failed to ensure clear width requirements for 1 of 5 corridor. 2. All residents have the potential to be affected by this deficient practice. 3. McGivney Maintenance removed the table from area. 4. Maintenance will include corridor clear in his weekly log. 	09/01/2022

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K 0293 SS=E Bldg. 01	<p>(e) the fixed furniture groupings addressed in LSC 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet.</p> <p>(f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment.</p> <p>(g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with LSC 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space.</p> <p>(h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with LSC 19.3.5.8 This deficient practice could affect all residents, staff and visitors exiting the facilities main ambulance entrance Hallway.</p> <p>Findings:</p> <p>Based on a facility tour and interview with the Maintenance Director on 08/15/22 between 11:45 a.m. and 2:00 p.m., the ambulance entrance corridor contained two chairs and one folding table extending into the approximately corridor 37 inches. The aforementioned furniture items were free standing, not affixed to the wall or floor.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director present at 2:15 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 Exit Signage Exit Signage</p>			

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	<p>2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.</p> <p>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 install exit signage in 1 of 3 kitchen exits in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect 6 staff in the kitchen area.</p> <p>Findings include: Based on a facility tour and interview with the Maintenance Director on 08/15/22 between 11:45 a.m. and 2:00 p.m., two doors leading out of the kitchen area and into the dining area were not marked as exits. The third door out of the kitchen leading into the exit corridor was not marked as an exit. The hood suppression pull station was located nearest the exit corridor door. At the time of observation, the Maintenance Director acknowledged the conditions that the kitchen did not have a door marked as an exit and confirmed that the path of egress was not obvious.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and</p>	K 0293	<p>K293</p> <p>1. The facility failed to install exit signage in 1 of 3 kitchen exits.</p> <p>2. All dietary staff have the potential to be affected by this deficient practice.</p> <p>3. McGivney Maintenance installed exit sign above the kitchen exit that was cited.</p>	09/01/2022

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K 0321 SS=E Bldg. 01	<p>again at the exit conference with the Maintenance Director present at 2:15 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101</p> <p>Hazardous Areas - Enclosure</p> <p>Hazardous Areas - Enclosure</p> <p>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.</p> <p>Describe the floor and zone locations of hazardous areas that are deficient in</p> <p>REMARKS.</p> <p>19.3.2.1, 19.3.5.9</p> <table> <tr> <td>Area</td> <td>Automatic Sprinkler</td> </tr> <tr> <td>Separation</td> <td>N/A</td> </tr> <tr> <td>a. Boiler and Fuel-Fired Heater Rooms</td> <td></td> </tr> <tr> <td>b. Laundries (larger than 100 square feet)</td> <td></td> </tr> <tr> <td>c. Repair, Maintenance, and Paint Shops</td> <td></td> </tr> <tr> <td>d. Soiled Linen Rooms (exceeding 64 gallons)</td> <td></td> </tr> <tr> <td>e. Trash Collection Rooms (exceeding 64 gallons)</td> <td></td> </tr> <tr> <td>f. Combustible Storage Rooms/Spaces (over 50 square feet)</td> <td></td> </tr> <tr> <td>g. Laboratories (if classified as Severe Hazard - see K322)</td> <td></td> </tr> </table>	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)				
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K 0324 SS=E Bldg. 01	<p>Based on observation and interview, the facility failed to ensure the corridor doors to 2 of 2 hazardous rooms were provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 10 residents.</p> <p>Findings include:</p> <p>Based on a facility tour and interview with the Maintenance Director on 08/15/22 between 11:45 a.m. and 2:00 p.m., the corridor doors to the following hazardous areas did not meet the requirements for protection of a hazardous area:</p> <ul style="list-style-type: none"> a) Basement room # 8, which was larger than 50 square feet and contained lots and lots of spare parts, chairs, boxes and other combustible items and was not self-closing. b) Basement room # 6, which was larger than 50 square feet and contained over 100 boxes of single use supplies, PPE and other combustible materials and was not self-closing. <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director present at 2:15 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited</p>		K 0321	<p>K321</p> <p>1. The facility failed to ensure the corridor doors to 2 of 2 hazardous rooms were provide with a self closing device.</p> <p>2. All staff have the potential to be affected by this deficient practice.</p> <p>3. McGivney Maintenance installed self closing device to the two doors.</p>	(X5) COMPLETION DATE 09/01/2022

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	<p>cooking in accordance with 18.3.2.5.2, 19.3.2.5.2</p> <p>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or</p> <p>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.</p> <p>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.</p> <p>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen fire suppression system was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices. Hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect staff in the kitchen and 15 residents in the dining room.</p> <p>Findings include:</p> <p>Based on records review and interview with the Maintenance Director on 08/15/22 between 9:45 a.m. and 11:45 a.m., the only documentation of annual kitchen suppression system inspection available for review was dated from November of 2021 by the facility's former contractor. Current</p>	K 0324	<p>K324</p> <p>1. The facility failed to ensure kitchen fire suppression system was inspected semiannually.</p> <p>2. All staff and resident have the potential to be affected by this deficient practice.</p> <p>3. McGivney Maintenance had the kitchen fire suppression system inspected and tested 8/29/22 by Siemens. Maintenance Director will place a placard identification above the K class extinguisher.</p> <p>4. Gibault Maintenance Facility Director will schedule and track for kitchen fire suppression system semiannually.</p> <p>Report was corrected and is attached.</p>	08/29/2022

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K 0372 SS=E Bldg. 01	<p>semiannual kitchen suppression was not completed. The Maintenance Director contacted the main office and determined that the current contract with the facility's new contractor didn't include kitchen hood suppression and that it would be added and scheduled immediately.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director present at 2:15 p.m.</p> <p>3.1-19(b)</p> <p>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.</p> <p>19.3.7.3, 8.6.7.1(1)</p> <p>Describe any mechanical smoke control system in REMARKS.</p> <p>Based on observation and interview, the facility failed to ensure all smoke barriers walls were 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</p>	K 0372	<p>K372</p> <ol style="list-style-type: none"> The facility failed to ensure all smoke barriers walls were protected to maintain the smoke resistance of each smoke barrier All staff and resident have the potential to be affected by this deficient practice. McGivney Maintenance 	09/01/2022

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K 0374 SS=F Bldg. 01	<p>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.</p> <p>Findings include:</p> <p>Based on a facility tour and interview with the Maintenance Director on 08/15/22 between 11:45 a.m. and 2:00 p.m., approximately a 6-inch X 3-foot opening in the smoke barrier ceiling was discovered near the furnace room in the basement. The Maintenance Director stated he was unsure why the condition existed but would correct it.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director present at 2:15 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes.</p>			placed $\frac{3}{4}$ fire resistant plywood over the deficient area.

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	<p>Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.</p> <p>19.3.7.6, 19.3.7.8, 19.3.7.9</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect all residents.</p> <p>Findings include:</p> <p>Based on a facility tour and interview with the Maintenance Director on 08/15/22 between 11:45 a.m. and 2:00 p.m., the set of smoke barrier doors near the nurse's station did not close completely leaving approximately a 2-inch gap. Based on interview during the time of observations, the Maintenance Director acknowledged these smoke barrier doors did not close completely and stated that he is constantly adjusting the aforementioned double door set.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director present at 2:15 p.m.</p> <p>3.1-19(b)</p>	K 0374	<p>K374</p> <p>1. The facility failed to ensure 1 of 1 set of smoke barrier doors would restrict the movement of smoke for at least 20 minutes.</p> <p>2. All staff and resident have the potential to be affected by this deficient practice.</p> <p>3. McGivney Maintenance adjusted the door frame to completely seal the doors shut.</p>	09/01/2022

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K 0500 SS=C Bldg. 01	<p>NFPA 101</p> <p>Building Services - Other</p> <p>Building Services - Other</p> <p>List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on records review and interview with the Maintenance Director on 08/15/22 between 9:45 a.m. and 11:45 a.m., the 3 of the facilities 3 gas fired water heaters had expired or missing Certificate of Inspection documentation from the State of Indiana. The documentation provided showed the aforementioned appliances expired on 06/12/19.</p> <p>Based on interview at the time of the observations, the Maintenance Director stated documentation of current Certificate of Inspection documentation is kept in no other location than at the service water heater locations or in the life safety book and acknowledged the aforementioned service water heaters had expired or missing Certificate of Inspection documentation from the State of Indiana.</p>	K 0500	<p>K500</p> <ol style="list-style-type: none"> 1. The facility failed to ensure 3 of 3 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. 2. All staff and resident have the potential to be affected by this deficient practice. 3. McGivney Maintenance scheduled State of Indiana to do a boiler inspection of water heaters. Schedule for 9/16/22. 	09/16/2022

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K 0511 SS=E Bldg. 01	<p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director present at 2:15 p.m.</p> <p>3.1-19(b)</p> <p>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.</p> <p>18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2</p> <p>1. Based on observation, the facility failed to ensure 1 of 1 electrical junction boxes under the stairs were maintained in a safe operating condition. 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, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect staff and 6 staff near the mechanical room.</p> <p>Findings include:</p> <p>Based on a facility tour and interview with the Maintenance Director on 08/15/22 between 11:45 a.m. and 2:00 p.m., an electrical junction box under the stairs did not contain a cover and had exposed electrical wiring. Based on interview at the time of the observations, the Maintenance Director</p>		K 0511	<p>K511</p> <p>1. The facility failed to ensure 1 of 1 electrical junction boxes under the stairs were maintained in a safe operating condition.</p> <p>2. All staff and resident have the potential to be affected by this deficient practice.</p> <p>3. McGivney Maintenance deleted the outlet and placed a solid cover over the electric junction box.</p> <p>4. All three electrical outlets near wet locations have been replaced by GFCI outlets, Pictures were attached.</p>	09/01/2022

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	<p>acknowledged the electrical junction box was not provided with a cover suitable for the box size and had exposed wires.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director present at 2:15 p.m.</p> <p>2. Based on observation and interview, the facility failed to ensure 3 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.</p> <p>(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.</p> <p>(1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors</p> <p>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.</p> <p>Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and</p>			

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	<p>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.</p> <p>(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.</p> <p>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.</p> <p>(6) Indoor wet locations</p> <p>(7) Locker rooms with associated showering facilities</p> <p>(8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools.</p> <p>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 4 residents and 2 staff.</p> <p>Findings include:</p> <p>Based on a facility tour and interview with the Maintenance Director on 08/15/22 between 11:45 a.m. and 2:00 p.m., the (1) ice machine in the</p>			

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K 0781 SS=E Bldg. 01	<p>kitchen was connected to an electric receptacle which was being used to power the freestanding ice machine, with its own water supply. The ice machine was located within 3 feet of the electric receptacle, and not provided with ground fault circuit interruption (GFCI). (2) The exterior outlet overhead immediately outside exit door number 2 was not a GFCI protected outlet and was not believed to be on a GFCI circuit. And (3) the bathroom in resident room number 3 had a receptacle within 3 feet of the sink which, when tested was not a GFCI outlet nor connected to a GFCI circuit breaker. The Maintenance Director at the time of observation stated he did not believe the receptacle was on a GFCI circuit.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director present at 2:15 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation and interview, the facility failure to ensure 1 of 1 portable space heaters were not used in the facility. This deficient practice could affect up to 3 residents, staff and visitors in the Charge Nurses office.</p> <p>Findings include:</p>	K 0781	<p>K781</p> <ol style="list-style-type: none"> 1. The facility failed to ensure 1 of 1 portable space heaters were not used in the facility 2. All staff and resident have the potential to be affected by this deficient practice. 	08/15/2022

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K 0918 SS=F Bldg. 01	<p>Based on a facility tour and interview with the Maintenance Director on 08/15/22 between 11:45 a.m. and 2:00 p.m., a portable space heater was observed in the Charge Nurses Office. Based on interview at the time of the observations, the Maintenance Director agreed a space heater was present and the facility did not allow such appliances and it would be removed shortly.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director present at 2:15 p.m.</p> <p>3.1-19(b)</p> <p>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</p>		<p>3. McGivney Maintenance discarded the portable space heater from the facility.</p> <p>4. McGivney Maintenance will include checking for space heaters in offices on his weekly log.</p>	

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	<p>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.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>1. Based on record review and interview, the facility failed to exercise the generator for 12 of 12 months to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems. 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, Chapter 8. NFPA 110 Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>(1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer</p> <p>(2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating.</p> <p>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</p>	K 0918	<p>K918</p> <p>1. The facility failed to exercise the generator for 12 of 12 months to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems.</p> <p>2. All staff and resident have the potential to be affected by this deficient practice.</p> <p>3. McGivney Maintenance updated their generator log sheet to include the percentage of load every week.</p> <p>4. McGivney ED will monitor generator log for 3 months for 100% compliance</p>	09/01/2022

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	<p>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 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. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review and interview with the Maintenance Director on 08/15/22 between 9:45 a.m. and 11:45 a.m., no documentation was available for review to show the available percentage of load placed upon the generator during monthly load tests. Based on an interview at the time of record review, the Maintenance Director stated he was unaware that he needed to record and keep a record of the percentage of load placed upon the generator during the monthly load tests.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director present at 2:15 p.m.</p> <p>2. 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 EPS shall be exercised under load for four continuous hours at least once within every three years. Section 8.4.9.5.1 states for a diesel-powered EPS, loading shall be not less than 30 percent of the</p>			

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K 0920 SS=D Bldg. 01	<p>nameplate kW rating of the EPS. A supplemental load bank shall be permitted to be used to meet or exceed the 30 percent requirement. 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.</p> <p>Findings include:</p> <p>Based on records review and interview with the Maintenance Director on 08/15/22 between 9:45 a.m. and 11:45 a.m., the facility provided documentation for testing of the emergency generator, however, could not provide documentation of a three-year 4-hour test under load. This was confirmed by the Maintenance Director who stated he was unaware of the requirement and had previously not been keeping records pertaining to load percentages during the monthly load test.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director present at 2:15 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 Electrical Equipment - Power Cords and Extents Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet</p>				

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	<p>the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 1 staff in the Boiler Room.</p> <p>Findings include:</p> <p>Based on a facility tour and interview with the Maintenance Director on 08/15/22 between 11:45 a.m. and 2:00 p.m., in the water heater/boiler room an extension cord was being used to power the most recently installed 100-gal water heater. The Maintenance Director agreed the wiring appeared to be an extension cord plugged into an outlet.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance</p>	K 0920	<p>K920</p> <ol style="list-style-type: none"> 1. The facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. 2. All staff and resident have the potential to be affected by this deficient practice. 3. McGivney Maintenance installed new junction box and conduit for the fixed wiring. 	09/01/2022

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	Director present at 2:15 p.m. 3.1-19(b)			