STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING -- B. WING	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(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: 12/08/22 Facility Number: 000273 Provider Number: 15A011 AIM Number: 100267870 At this Emergency Preparedness survey, Especially Kidz Health & Rehab was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 130 certified beds. At the time of the survey, the census was 129. Quality Review completed on 12/13/22	E 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.	
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).	K 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dawn Wendel	Administrator	01/06/2023

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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	Survey Date: 12/08/22 Facility Number: 000273 Provider Number: 15A011 AIM Number: 100267870 At this Life Safety Code survey, Especially Kidz Health & Rehab was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, the NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) 2012 Edition and 410 IAC 16.2. The original building, Building 01, and the 2009 addition, Building 02, were each surveyed with Chapter 19, Existing Health Care Occupancies as one building. This one story facility 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, in all areas open to the corridor and in resident sleeping rooms 17 through 30. Battery operated smoke detectors are installed in all other resident sleeping rooms. The facility has a capacity of 130 and had a census of 129 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were not sprinklered. Quality Review completed on 12/13/22		alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.	
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in			

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	accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 1 of 12 battery powered emergency lighting systems was maintained in accordance with LSC Section 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70, National Electric Code. This deficient practice could affect over 4 residents, staff and visitors in resident sleeping Room F. Findings include: Based on observations with the Maintenance Director and the Assistant Administrator during a tour of the facility from 12:40 p.m. to 2:55 p.m. on 12/08/22, the battery operated lighting system affixed to the ceiling above the corridor entry door in Room F failed to illuminate when its respective test button was pushed multiple times. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned battery powered emergency lighting system failed to illuminate when its respective test button was pushed multiple times. This finding was reviewed with the Administrator, Assistant Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0291	**K 291 Requires the facility to provide emergency lighting** 1. 1. One battery powered emergency lighting system above room F failed to illuminate. 2. 2. This practice has the potential to affect resident, staff and visitors in room F 3. 3. The emergency lighting system was switched out with a new one the same day as the survey. An audit of all exiting lighting was completed. 4. 4. The Maintenance Director or his designee will conduct weekly rounds to ensure lighting systems are in working order. **(Attachment A)** Preventative maintenance logs will be reviewed quarterly during quality assurance meetings with the plan of action adjusted accordingly. 5. 5. The above corrective measure was completed on December 8, 2022.	12/08/2022
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure			

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	Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of over 14 hazardous areas such as trash collection rooms exceeding 64 gallons of trash were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the	K 0321	1. 1. Hazard waste room door was not self-closing. 2. 2. This practice has the potential to affect residents, staff and visitors in the vicinity of the Biohazard Storage room. 3. 3. A self-closure was attached to the biohazard storage	12/09/2022

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	Biohazard Storage room near the main fire alarm control panel room. Findings include: Based on observations with the Maintenance Director and the Assistant Administrator during a tour of the facility from 12:40 p.m. to 2:55 p.m. on 12/08/22, the corridor door to the Biohazard Storage room near the main fire alarm control panel room was not automatic closing or self closing. The Biohazard Storage room contained trash collection carts exceeding 64 gallons in combined capacity and also contained plastic red bag waste storage bags filled with red bag waste. Based on interview at the time of the observations, the Maintenance Director and the Assistant Administrator agreed the corridor door to the aforementioned hazardous area was not automatic closing or self closing. This finding was reviewed with the Administrator, Assistant Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		room. **(Attachment B photo)** 4. 4. The maintenance director or his designee will continue to monitor self-closures as part of the preventative maintenance program. 5. 5. The above corrective measure was completed on December 9, 2022	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in			

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	smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to install the kitchen range hood system in accordance with the requirements of LSC Section 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 edition, Section 6.1.1 states listed grease filters, listed baffles, or other listed grease removal devices for use with commercial cooking equipment shall be provided. Section 6.2.3 states grease filters shall be arranged so that all exhaust air passes through the grease filters. Section 6.2.3.5 states grease filters shall be installed at an angle not less than 45 degrees from the horizontal. Section 6.2.5. states grease filters that require a specific orientation to drain grease shall be clearly so designated, or the hood shall be constructed so that filters cannot be installed in the wrong orientation. This deficient practice could affect over two staff in the kitchen. Findings include: Based on observations with the Maintenance Director and the Assistant Administrator during a tour of the facility from 12:40 p.m. to 2:55 p.m. on 12/08/22, four of four grease filters in the kitchen	K 0324	1. 1. The kitchen hood exhaust grease filters were oriented parallel to floor and not perpendicular as required to allow grease drainage. 2. 2. This practice has the potential to affect employees in the kitchen. 3. 3. New grease filters were ordered and displayed perpendicular to the drip tray. **(Attachment C photo)** 4. 4. The maintenance director or his designee will continue to monitor and ensure the filters remain in appropriate placement. 5. 5. The above correct measure was completed on December 22, 2022.	12/22/2022

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	range hood system above the range were oriented parallel to the floor and were not oriented perpendicular to the floor to allow grease to drain into the drip tray at the bottom of the grease filters. Based on interview at the time of the observations, the Maintenance Director and the Assistant Administrator agreed four of four grease filters in the kitchen range hood system above the range were not oriented perpendicular to the floor to allow grease to drain into the drip tray at the bottom of the grease filters. This finding was reviewed with the Administrator, Assistant Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the	K 0353	1. Sprinkler system was	04/01/2023

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	facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 5.3.1.1.3 states where required by this section, sample sprinklers shall be submitted to a recognized testing laboratory acceptable to the authority having jurisdiction for field service testing. NFPA 25, Section 5.3.1.3 states where one sprinkler within a representative sample fails to meet the test requirement, all sprinklers within the area represented by that sample shall be replaced. NFPA 25, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the laboratory testing contractor's "Reference Number: 51070" sprinkler testing documentation dated 10/30/19 with the Administrator, Assistant Administrator and the Maintenance Director during record review from 9:15 a.m. to 12:40 p.m. on 12/08/22, a representative sample of dry pendant sprinklers installed in the facility failed laboratory testing. The 10/30/19 testing documentation stated the		inspected 10/30/19. Two standard dry pendant sprinklers did not pass inspection. Additionally one sprinkler in the biohazard storage room had red plastic attached to the deflector. 2. This practice has the potential to affect all residents, staff and visitors in the facility. 3. The plastic was removed from the deflector. An audit of all sprinklers in the facility was completed without incident. The maintenance director or his designee will conduct weekly rounds to ensure compliance. **(Attachment A)** As a means of quality assurance for the installation of the remaining sprinkler heads, the facility will continue to remain in contact via email for documentation purposes with the contractor for delivery and installation of the remaining sprinkler heads that have been ordered. 4. While the sprinklers that remain are in working order and tied into the fire alarm panel, immediate inservicing began (and will be ongoing) for all staff ensuring their knowledge and location of fire pull stations, fire extinguishers and respect of automated sprinklers. **(Attachment D)** 5. The waiver requests a deadline of April 1, 2023 to accommodate any shipping and availability delays. **(Attachment**	

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	standard response dry sprinkler identified as "Sprinkler Number 182339-1" installed in the "Old system by real attic door" which was manufactured in 1983 failed testing. Two standard response dry pendant sprinklers identified as "Sprinkler Number 182340-1" and "Sprinkler Number 182342-3" which were manufactured in 1977 and installed in the "Hallway/Walkway" and one standard response dry pendant sprinkler identified as "Sprinkler Number 182341-2" which was manufactured in 1977 and installed in the "Laundry Room" also failed testing. The results of testing each of the aforementioned sprinklers was stated as "Abnormal-No Waterflow" and "The release mechanism (heat responsive element) operated, but the sprinkler water seal assembly did not release at the applied test water pressure of 7 psig to allow discharge of water". Based on interview at the time of record review, the Maintenance Director stated the facility is in the process of having a contractor change out all sprinklers in the facility following the 10/30/19 sprinkler testing results but not all sprinklers have been replaced by the contractor at the time of this survey. The Maintenance Director stated he did not have documentation from the sprinkler contractor stating what areas of the facility had sprinklers replaced to date. Based on telephone interview with the sprinkler contractor during record review, the sprinkler contractor stated supply chain issues since 2020 due to Covid-19 has delayed sprinkler replacement and provided a "Scope Letter" dated 12/08/22 to the facility during the survey stating the contractor has "replaced approximately 70% of the building with the remaining sprinklers currently on back order" from the manufacturer. This finding was reviewed with the Administrator, Assistant Administrator and the Maintenance		**E)**	

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	Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of over 100 sprinkler heads in the facility were not loaded with foreign materials in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Biohazard Storage room near the main fire alarm control panel room. Findings include: Based on observations with the Maintenance Director and the Assistant Administrator during a tour of the facility from 12:40 p.m. to 2:55 p.m. on 12/08/22, one of three ceiling mounted sprinklers			

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	in the Biohazard Storage room near the main fire alarm control panel room had red plastic attached to the deflector. Based on interview at the time of the observations, the Maintenance Director and the Assistant Administrator agreed the aforementioned automatic sprinkler location was loaded with a foreign material and had facility staff remove the red plastic from the deflector. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. 1. Based on observation and interview, the facility failed to ensure 1 of 9 smoke barrier walls were protected to maintain the fire resistance rating of the smoke barrier wall. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect over 20 residents,	K 0372	1. 1. The can lights above the nurses' station and nutrition room had manufacturer openings that exposed the attic. In the attic red fire caulk had dried out and exposed a hole in the attic smoke barrier. 2. 2. This practice has the	12/12/2022

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	staff and visitors near the vicinity of the smoke barrier wall by the new unit nurse's station. Findings include: Based on observations with the Maintenance Director and the Assistant Administrator during a tour of the facility from 12:40 p.m. to 2:55 p.m. on 12/08/22, the following was noted: a. expandable foam was used to firestop the annular space surrounding two conduits which penetrated the attic smoke barrier wall above the corridor door set by the new unit nurse's station. b. red fire rated caulk was used to fill the hole in the wall for the black conduit, two white data cables and one purple data cable which penetrated the attic smoke barrier wall above the corridor door set by the new unit nurse's station. The red caulk had dried out and contracted in the hole which left a gap in the exposed hole. Based on interview at the time of the observations, the Maintenance Director stated he was not aware of the UL listing of the expandable foam used to firestop the attic penetrations and agreed the aforementioned openings in the attic smoke barrier wall were not firestopped to maintain the fire resistance rating of the smoke barrier wall. This finding was reviewed with the Administrator, Assistant Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure openings through 1 of 1 ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes and		potential to affect residents, staff and visitors near the vicinity of the smoke barrier wall by the new unit nursing station. 3. 3. Fresh red fire caulk was applied to the noted area. New can lights were ordered without openings and replaced out the old can lights. **(Attachment F & photo)** 4. 4. The facility will continue preventative maintenance rounds per policy. 5. 5. The above corrective measure was completed 12/12/2022	

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	15A011	A. BUILDING 01 B. WING	12/08/2022

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	similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the new unit nurse's station. Findings include: Based on observations with the Maintenance Director and the Assistant Administrator during a tour of the facility from 12:40 p.m. to 2:55 p.m. on 12/08/22, four of four can lights installed in the ceiling above the new unit nurse's station had a four inch hole above the light in the can light fixture which exposed the attic above. One can light in the Nourishment Room near the new unit nurse's station had the same type of lighting fixture installed in the ceiling of the room which exposed the attic above. The hole in the lighting fixtures was not smoke resistant and exposed the attic above. Based on interview at the time of the observations, the Maintenance Director stated the lighting fixtures were installed around 2009 but agreed the holes in the lighting fixtures in the ceiling did not ensure the ceiling smoke barrier was protected to maintain the fire resistance rating of the smoke barrier. This finding was reviewed with the Administrator, Assistant Administrator and the Maintenance Director during the exit conference.			

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K 0521 SS=E Bldg. 01	3.1-19(b) NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on observation and interview, the facility failed to ensure 5 of 6 egress corridors in the original building were not being used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a potion of a supply return or exhaust air system serving adjoining areas. This deficient practice could affect over 32 residents in the original portion of the facility. Findings include: Based on interview with the Maintenance Director during the entrance conference at 9:00 a.m. on 12/08/22, egress corridors in the original building use the corridor as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. The Maintenance Director stated the facility applies for a waiver whenever it is cited in a Life Safety survey and there has been no changes to the HVAC system since it was last cited. Based on observations with the Maintenance Director and the Assistant Administrator during a tour of the facility from 12:40 p.m. to 2:55 p.m. on 12/08/22, five of six egress corridors in the original building were	K 0521	1. Egress corridors in the original building were not being used as a portion of a return air system/plenum for heating. 2. Residents in the original portion of the facility have the potential to be affected. 3. There have been no changes in the facility structure. 4. As a means of quality assurance, the facility will continue to complete preventative maintenance on all fire prevention equipment and HVAC equipment as required by the preventative maintenance schedule. 5. As a means to ensure ongoing compliance an annual request for a waiver was completed. **(Attachment G)** 12/19/22	12/19/2022

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	being used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. This finding was reviewed with the Administrator, Assistant Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0907 SS=E Bldg. 01	NFPA 101 Gas and Vacuum Piped Systems - Maintenance Pr Gas and Vacuum Piped Systems - Maintenance Program Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99) Based on record review and interview, the facility failed to maintain the facility's piped gas systems in accordance with NFPA 99, Health Care Facilities Code, 2012 Edition. This deficient practice could affect over 20 residents should the facility's piped gas system not be operational. Findings include:	K 0907	1. 1. The non-urgent repairs to the piped gas system were not completed in a timely manner. 2. 2. There were no residents harmed by the citation. The deficit has the potential to affect over 20 residents. The “Scope of Work” states an existing system that is	01/03/2023

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	Based on review of the piped gas system inspection contractor's "Medical Piped Gas Inspection" documentation dated 10/17/22 to 10/20/22 with the Administrator, Assistant Administrator and the Maintenance Director during record review from 9:15 a.m. to 12:40 p.m. on 12/08/22, annual inspection documentation for the facility's piped gas systems within the most recent twelve month period indicated 19 of 160 inventory items were listed as "Unacceptable" for items inspected or tested. The October 2022 inspection documentation also listed 15 "Work orders opened during the inspection", zero "Work orders closed during current inspection" and 8 "Work orders open from prior inspections" for a total of 23 "Remaining Open Work Orders". The items found to have unacceptable results were for the "Master Alarm Panels, Master Alarm Panel Modules, Area Alarm Panel Modules, Zone Valve Boxes, Zone Valves, Gas & Vacuum System Source(s) and Patient Terminals". The "Scope of Work" section of the October 2022 inspection documentation defined "Unacceptable" as "These items represent findings which need to be addressed by the facility in the immediate future or during future renovations" and defined "Repair Orders" as "These items represent findings which do not meet the NFPA 99 requirements for existing medical gas systems and/or constitute a distinct hazard to life. These items shall be corrected in a timely manner as necessary funding, parts, and access are made available". Based on interview at the time of record review, the Maintenance Director stated repairs following the October 2022 inspections have not yet been made and provided documentation from the inspection contractor stating the contractor was expected on site 01/03/23 for repairs.		not in strict compliance with the provisions of this standard shall be permitted to be continued in use as long as the authority having jurisdiction has determined that such use does not constitute a distinct hazard to life." **(Attachment H)** 3. 3. The facility continues to have maintenance contracts that ensure inspections are completed in a timely manner. 4. 4. As a means of quality assurance, should any repairs be identified at the time of the inspection, the facility will insist upon a repair date prior to the inspectors leaving the facility. **5. 5.** The scheduled repairs were completed on January 3, 2023 with no further repairs necessary. Attachment J	

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	This finding was reviewed with the Administrator, Assistant Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			