STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155661	A. BUILDING -- B. WING	02/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OWEN VALLEY REHABILITATION AND HEALTHCARE CENTER	920 W HIGHWAY 46 SPENCER, IN 47460

(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: 02/19/24 Facility Number: 010892 Provider Number: 155661 AIM Number: 200229560 At this Emergency Preparedness survey, Owen Valley Rehabilitation and Healthcare Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 113 certified beds, with a current census of 74. Quality Review completed on 02/22/24	E 0000	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of compliance effective March 5, 2024. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the Plan of Correction (POC) and supporting documents submitted.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cathy Parker	Executive Director	03/05/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to develop and maintain an emergency	E 0004	The filing of this plan of correction does not constitute an admission	03/05/2024

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	preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan on 02/19/24 between 11:55 a.m. to 12:25 p.m. with the Senior Maintenance Director and Director of Maintenance, documentation for an emergency preparedness plan updated or reviewed by the facility within the most recent twelve-month period was not available for review. The last documented date of the emergency plan provided was 01/31/2023. Based on interview at the time of record review, the Sr Maintenance Director agreed that according to the documentation provided, the facility could not show proof of an annual update of its entire emergency preparedness program reviewed by the facility within the most recent twelve-month period. This finding was reviewed with the Administrator in Training, Senior Maintenance Director and Director of Maintenance at the exit conference.		the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of compliance effective March 5, 2024. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the Plan of Correction (POC) and supporting documents submitted. **E 004-Develop Emergency Preparedness plan, Review and Update Annually.** The facility does ensure that it has an emergency preparedness plan (EP). **Immediate actions taken:** The ED/Maintenance director will update the Emergency Preparedness plan and ensure that it is updated and reviewed as indicated. **How the facility identified other residents.** No residents were identified as being affected by the deficient practice. **Measures put into place/System changes:** The ED and maintenance director reviewed the EP plan and updated with any changes as indicated.	

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			Monitoring of corrective action taken: The Executive Director or designee will ensure the updated EP plan is reviewed during the next Quality Assurance and Process Improvement (QAPI) meeting and annually thereafter. **Date of Compliance: March 5, 2024**	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph			

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	(a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water			

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	supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's Emergency Preparedness Plan on 02/19/24 between 11:55 a.m. to 12:25 p.m. with the Senior Maintenance Director and Director of Maintenance, documentation of emergency preparedness policies and procedures updated or reviewed by the facility within the most recent twelve-month period was not available for review. The most recent documented update to the emergency plan provided was dated 01/31/2023. Based on interview at the time of record review, the Sr Maintenance Director agreed that according to the documentation provided, the facility could not show proof of an annual update of its emergency preparedness policies and procedures reviewed by the facility within the most recent twelve-month period. This finding was reviewed with the Administrator in Training, Senior Maintenance Director and Director of Maintenance at the exit conference.	E 0013	**E 013-Development of Policies and Procedures.** The facility does ensure policy and procedures are in place for the Emergency Preparedness program. **Immediate action taken:** The facility will ensure the EPs plan policy and procedures are updated no less than annually. **How the facility identified other residents.** No residents were identified as being affected by the deficient practice. **Measures put into place/System changes:** The ED will ensure that the policies and procedures are reviewed and updated. **Monitoring of corrective action taken:** The ED or designee will ensure the communication plan for the EP plan is submitted at the next Quality Assurance and Process Improvement Plan meeting, and then annually thereafter. **Date of Compliance: March 5, 2024**	03/05/2024
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan			

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	§403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan on 02/19/24 between 11:55 a.m. to 12:25 p.m. with the Senior Maintenance Director and Director of Maintenance, documentation of an emergency preparedness communication plan updated or reviewed by the facility within the most recent twelve-month period was not available for review. The communication plan provided had a documented update of 01/31/2023. Based on interview at the time of record review, the Senior Maintenance Director agreed that according to the documentation provided, the facility could not show proof of an annual update of its emergency preparedness policies and procedures reviewed by the facility within the most recent twelve-month period. This finding was reviewed with the Administrator	E 0029	**E 029-Development of Communication Plan.** The facility does have an emergency preparedness communication plan. **Immediate action taken:** Communication plan was updated and will be reviewed at the next Quality Assurance and Process Improvement Plan Meeting. **How the facility identified other residents.** No residents were identified as being affected by this deficient practice. **Measures put in place/System changes:** The ED or designee will review and update if applicable the EP's communication plan. **Monitoring of corrective action taken:** The ED or designee will submit the communication plan at the next QAPI for review and then annually thereafter. **Date of Compliance: March 5, 2024**	03/05/2024

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	in Training, Senior Maintenance Director and Director of Maintenance at the exit conference.			
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a)			

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	of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in	E 0036	**E 036- Training and Testing** The facility does ensure that training and testing is completed for the EP plan.	03/05/2024

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	accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan on 02/19/24 between 11:55 a.m. to 12:25 p.m. with the Senior Maintenance Director and Director of Maintenance, documentation of an emergency preparedness training and testing program updated or reviewed by the facility within the most recent twelve-month period was not available for review. The training and testing program provided had not been reviewed within the past twelve months, with the last documented date of update being listed as 01/31/2023. Based on interview at the time of record review, the Senior Maintenance Director agreed that according to the documentation provided, the facility could not show proof of an annual update of its emergency preparedness training and testing program reviewed by the facility within the most recent twelve-month period. This finding was reviewed with the Administrator in Training, Senior Director of Maintenance and Director of Maintenance at the exit conference.		**Immediate action taken:** The Executive Director will ensure the training and testing requirement of the EP plan will be reviewed and updated if applicable. **How the facility identified other residents.** No residents were affected by this deficient practice. **Measures put into place/System changes.** ED or designee will ensure that training and testing requirement for the EP plan is met. **Monitoring of corrective action taken:** The ED or designee will review and update if applicable the EP's training and testing requirement at the next QAPI meeting and then annually thereafter. **Date of Compliance: March 5, 2024**	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e)			

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155661	A. BUILDING -- B. WING	02/19/2024

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	22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). Based on record review and interview, the facility failed to ensure documentation for 1 of 1 emergency generators included a 5 minute cool down period after a load test, plus a transfer time to the alternate power source on the monthly load tests during the past 12 months to ensure the alternate power supply was capable of supplying service within 10 seconds. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110, 6.4.2.1.5.9 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review on 02/19/24 at 11:50 a.m.	E 0041	**E 041-Documentation of EP Plan updating and/or reviewing in most recent twelve-month period.** The facility does maintain a log for the emergency generator. **Immediate action taken:** The emergency generator log was updated to include the correct cool down period after a load test. **How the facility identified other residents.** No residents were affected by this deficient practice. **Measures put into place/System changes:** An audit tool was developed, and the maintenance director will audit the weekly emergency generator log. To identify the cool down time so the alternate power supply was capable of supplying service within 10 seconds. **Monitoring of corrective action taken:** The audit logs will be submitted at the QAPI meeting. After two meetings if no issues are identified the QAPI team will discontinue monitoring of the generator log. **Date of Compliance: March 5, 2024.**	03/05/2024

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	with the Director of Maintenance and Senior Maintenance Director, the generator log forms for the months of November and December 2023 and January 2024 documented the generator was tested monthly under load; however, there was no documentation on the form that showed the generator had a cool down time following its load test. The cool down time area showed '0 minutes'. Additionally, the monthly load testing for the same months lacked documentation of a transfer time from normal power to emergency power. The transfer time to emergency power area showed '0 seconds'. At the time of record review, the Director of Maintenance confirmed there was no documentation of a cool down time or transfer time on the generator monthly load test form for the aforementioned months. This finding was reviewed with the Administrator in Training, Senior Maintenance Director and Director of Maintenance at the exit conference.			
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/19/24 Facility Number: 010892 Provider Number: 155661 AIM Number: 200229560 At this Life Safety Code survey, Owen Valley Rehabilitation and Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR	K 0000	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of compliance effective March 5, 2024. We respectfully request desk	

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	Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 113 and had a census of 74 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 02/22/24		review and consideration for paper compliance of substantial compliance based on the Plan of Correction (POC) and supporting documents submitted.	
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General 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. Based on observation and interview, the facility failed to maintain latching hardware on 1 of 5 double door set per Section 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect as many as 15 residents and staff. Findings include:	K 0100	**K100-Barrier doors failed to fully close and latch.** **Immediate action taken:** The door closure mechanism on the top of the door was adjusted so door shuts securely. **How the facility identified other residents.** No residents were affected by this deficient practice. **Measures put into**	03/05/2024

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	Based on observations made with the Director of Maintenance and Senior Maintenance Director on 02/19/24 at 1:02 p.m., the set of barrier doors by resident room 311 failed to fully close and latch when tested on three separate occasions. Based on an interview at the time of the observations, the Director of Maintenance agreed that the barrier doors by room 311 failed to fully close and latch at the time of the survey. This finding was reviewed with the Administrator in Training, Senior Maintenance Director and Director of Maintenance at the exit conference. 3.1-19(b)		**place/System changes.** An audit tool was developed and the fire barrier doors by room 311 will be checked daily for one month. Weekly for one month and Monthly for a period of four months. **Monitoring of corrective action taken:** Audit tools will be submitted at QAPI meeting and two QAPI meeting with no issues with the barrier doors and audits will be discontinued. **Date of Compliance: March 5, 2024**	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually:	K 0345	**K 345-Fire alarm System-Testing and Maintenance:** **Immediate action taken:** A visual inspection is scheduled for March of 2024. **How the facility identified other residents.** No residents were affected by this deficient practice. **Measures put into**	03/05/2024

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	a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 02/19/24 between 10:35 a.m. and 12:25 p.m. with the Director of Maintenance and Senior Maintenance Director present, there was documentation provided regarding an annual fire alarm system inspection dated 12/26/23 by the facility's fire alarm inspection vendor. The most recent documented semi annual visual inspection of the facility's fire alarm devices was dated 05/17/22. Based on interview at the time of record review, the Director of Maintenance confirmed the most recent semi-annual visual inspection of the fire alarm devices was 05/17/22 and no other documentation was available for review at the time of the survey. This finding was reviewed with the Administrator in Training, Senior Maintenance Director and Director of Maintenance during the exit conference. 3.1-19(b)		**place/System changes.** The maintenance director will complete visual inspection biannually and bring inspection logs to QAPI following the inspection. **Monitoring of corrective action taken:** The visual inspection log will be brought to QAPI meetings for review for two subsequent inspections and if no concerns the audits will discontinue. **Date of Compliance: March 5, 2024**	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment			

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	complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of over 20 wet locations, were provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would	K 0511	**K511-Utilities-Gas and Electric** **Immediate action taken:** The outlet was changed out to a ground fault circuit interrupter (GFCI) immediately. **How the facility identified other residents.** No residents were affected by the deficient practice. **Measures put into place/System changes.** Only one outlet located within 3 feet of a wet location was identified as not GFCI. **Monitoring of corrective action taken:** Maintenance Director will bring audit log of GFCI audit to the next QAPI meeting and will be reviewed. **Date of Compliance: March 5, 2024.**	03/05/2024

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	create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 30 residents and staff in the dining room. Findings include: Based on observations on 02/19/24 at 12:58 p.m. during a tour of the facility with the Director of Maintenance and Senior Maintenance Director, there was an electric receptacle within three feet of a sink in the Dining Room with no GFCI protection provided. When tested with a GFCI tester, the circuit on the receptacle was not broken. Based on interview at the time of each			

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	observation, the Director of Maintenance agreed the receptacle in question was not properly GFCI protected. This finding was reviewed with the Administrator in Training, Senior Maintenace Director, and Director of Maintenance during the exit conference. 3.1-19(b)			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure 2 of 12 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports	K 0712	**K 712: Fire Drills** **Immediate action taken:** Maintenance director was educated to ensure fire alarm is pulled when fire drill is completed so that our transmission of the fire alarm signal goes to the monitoring company. **How the facility identified other residents.** No residents were affected by this deficient practice. **Measures put into place/System changes.** Maintenance Director or designee	03/05/2024

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	on 02/19/24 between 10:35 a.m. and 12:25 p.m. with the Director of Maintenance and Senior Maintenance Director present, 2 of 12 fire drill reports performed during the past 12 month period were not provided with documentation for the transmission of the alarm to the monitoring company. The drills were dated 07/31/23 at 2:00 p.m. and 05/30/23 at 2:37 p.m. Based on interview at the time of record review, the Director of Maintenance stated he checked with the monitoring company and there was no information verifying transmission of the alarm for the 07/31/23 and 05/30/23 fire drill reports. This finding was reviewed with the Administrator in Training, Senior Maintenance Director and Director of Maintenance at the exit conference. 3-1.19(b) 3.1-51(c)		will audit the engaging of the fire alarm monthly. Will obtain documentation from the monitoring company that the fire alarm was engaged. **Monitoring of corrective action taken:** The maintenance Director or designee will bring the audit sheets to QAPI and after two QAPI meetings and no concerns for the fire alarm engagement, audits will be discontinued. **Date of Compliance: March 5, 2024.**	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include			

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	a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to ensure documentation for 1 of 1 emergency generators included a 5 minute cool down period after a load test, plus a transfer time to the alternate power source on the monthly load tests during the past 12 months to ensure the alternate power supply was capable of supplying service within 10 seconds. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110, 6.4.2.1.5.9 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the	K 0918	**K 918- Electric Systems** **Immediate action taken:** The Maintenance Director was educated to ensure the generator logs indicate a 5-minute cool down period to ensure the alternative power source can supply power with in 10 seconds. **Measures put into place/System changes.** In servicing completed with Maintenance Director for the cool down time for the alternate power source. Maintenance Director of Designee will audit weekly for four weeks, biweekly for four weeks and then monthly for four months. **Monitoring of corrective action taken:** The Maintenance Director or Designee will bring audit tools to the next QAPI for review. After	03/05/2024

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	facility. Findings include: Based on record review on 02/19/24 at 11:50 a.m. with the Director of Maintenance and Senior Maintenance Director, the generator log forms for the months of November and December 2023 and January 2024 documented the generator was tested monthly under load; however, there was no documentation on the form that showed the generator had a cool down time following its load test. The cool down time area showed '0 minutes'. Additionally, the monthly load testing for the same months lacked documentation of a transfer time from normal power to emergency power. The transfer time to emergency power area showed '0 seconds'. At the time of record review, the Director of Maintenance confirmed there was no documentation of a cool down time or transfer time on the generator monthly load test form for the aforementioned months. This finding was reviewed with the Administrator in Training, Senior Maintenance Director and Director of Maintenance at the exit conference. 3.1-19(b)		two QAPI and there are no concerns, the audits will be discontinued. **Date of Compliance: March 5, 2024.**	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens 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) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. 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 two staff. Findings include: Based on observation during a tour of the facility with the Director of Maintenance and Senior Maintenance Director on 02/19/24 at 12:30 p.m., a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in the Community Service Office. Based on interview at the time of observation, the Director of Maintenance confirmed a refrigerator was plugged into the power strip. This finding was reviewed with the Administrator in Training, Senior Maintenance Director and	K 0920	**K920-Electtrical Equipment** **Immediate action taken:** An Inservice was completed with management staff to ensure that high load draw equipment is plugged directly to the outlet and not to a power strip. **How the facility identified other residents.** No residents were affected by this deficient practice. **Measures put into place/System changes.** The Maintenance Director or designee will audit the high-power draw equipment in the offices weekly for four weeks. Monthly for four months. **Monitoring of corrective action taken:** The Maintenance Director of designee will submit audit tools at the next QAPI meeting. If no concerns are noted after two QAPI meetings the audits will be	03/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155661	A. BUILDING 01 B. WING	02/19/2024

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	Director of Maintenance at exit conference. 3.1-19(b)		discontinued. **Date of Compliance: March 5, 2024.**	