STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155202	A. BUILDING -- B. WING	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF GREENCASTLE, THE	1601 HOSPITAL DR GREENCASTLE, IN 46135

(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: 09/06/23 Facility Number: 000109 Provider Number: 155202 AIM Number: 100266290 At this Emergency Preparedness survey, The Waters of Greencastle was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 100 certified beds and had a census of 62 at the time of this visit. Quality Review completed on 09/11/23	E 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
E 0041 SS=C Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Etienne	Administrator	09/23/2023

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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	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 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			

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	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 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013.			

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	(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator on 09/06/23 from 9:35 a.m. to 12 :15 p.m., documentation for the weeks of 09/26/22 and 10/24/22 weekly generator testing was not available for review. Based on an interview at the time of record review, the Administrator confirmed weekly generator testing was not documented on the aforementioned weeks. This finding was reviewed with the Administrator and Director of Nursing at the exit conference.	E 0041	**E041**– It is the intent of the facility to ensure to implement the emergency power system requirements found in the health care facilities code, NFPA 110 and Life Safety Code in accordance with 42 CFR 483.73 (e)(2) to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. The Administrator will in-service the new Maintenance Supervisor/designee on September 29, 2023 on the requirement to perform weekly inspections of the emergency generator and document the results in the facilities Life Safety Binder to meet set standards. b. On September 9, 2023 the Maintenance Supervisor/designee performed the weekly inspection of the emergency generator and documented the results in the facilities Life Safety Binder to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. The Maintenance Supervisor/designee will ensure weekly inspections on the	09/09/2023

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K 0000 Bldg. 01			emergency generator are conducted and documented in the life safety binder to meet set standards. b. The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The Administrator and Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual to ensure it includes weekly inspections of the emergency generator to meet set standards. Those reviews will be documented as appropriate. The Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. Results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is September 9, 2023.**	

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	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: 09/06/23 Facility Number: 000109 Provider Number: 155202 AIM Number: 100266290 At this Life Safety Code survey, The Waters of Greencastle, was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This 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, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 100 and had a census of 62 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for three detached equipment storage sheds which were not sprinklered. Quality Review completed on 09/11/23	K 0000	**DISCLAIMER STATEMENT:** **Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
K 0300 SS=C Bldg. 01	NFPA 101 Protection - Other Protection - Other			

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	List in the REMARKS section any LSC Section 18.3 and 19.3 Protection 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.			
	1. Based on record review and interview, the facility failed to ensure the preventative maintenance for all battery operated smoke alarms in resident rooms was conducted according to manufacturer's published instructions. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents. Findings include: Based on records review with the Administrator on 09/06/23 at 10:25 a.m., the "Battery-Operated Smoke Detector Maintenance Log" showed monthly testing of the battery operated smoke alarms. The manufacturer's published instructions for the Kidde model i9040 smoke alarms stated the alarms require weekly testing. Based on interview at the time of records review, the Administrator stated the alarms are tested monthly, and agreed the alarms should be tested weekly according to manufacturer's published instructions. This finding was reviewed with the Administrator	K 0300	**K300**– It is the intent of the facility to ensure the preventative maintenance for all battery operated smoke alarms in resident rooms is conducted according to manufacturer's published instructions and to ensure documentation for the preventative maintenance of battery operated smoke alarms in the facility is complete to meet set standards. **1) CORRECTIVE ACTIONS TAKEN**: a) The Administrator will in-service the new Maintenance Supervisor/designee on September 29, 2023 on the requirement that battery operated smoke alarms must be maintained per manufacture's guidelines and tested on a weekly basis and documentation retained at the facility to meet set standards. b) On September 16, 2023 the Maintenance Supervisor/designee conducted the weekly inspection of the battery-operated smoke alarms and documented the information on the Battery-Operated Smoke Detector Maintenance Log to meet set standards. The Administrator verified the work on September 16,	09/16/2023

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	and Director of Nursing during the exit conference. 2. Based on record review, interview and observation; the facility failed to ensure documentation for the preventative maintenance of 24 of 48 battery operated smoke alarms in the facility was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of the Battery Operated Smoke Detector Maintenance Log on 09/06/23 from 89:35 a.m. to 12:15 p.m., testing for 24 of the 48 battery operated smoke alarm was not documented July and August 2023. Based on interview at the time of review, the Administrator confirmed the testing of 24 of 48 battery operated smoke detectors in the facility were not documented for July and August 2023, stating the Maintenance Director must have missed documenting the second page. Based on observations between 12:15 p.m. and 1:35 p.m. during a tour of the facility with the Administrator and Director of Nursing, battery operated smoke alarms were observed in all resident sleeping rooms. This finding was reviewed with the Administrator		2023. c) The Administrator will in-service the new Maintenance Supervisor/designee on September 29, 2023 on the requirement that all 48 battery operated smoke alarms must be tested per manufacture's guidelines and documentation retained at the facility to meet set standards. **2) ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a) All residents and all staff and visitors have the potential to be affected but none were. **3) MEASURES TO PREVENT REOCCURRENCE**: a) Maintenance Supervisor/designee will ensure all battery-operated smoke alarms are maintained per manufactures guidelines and tested on a weekly basis and will document the results on the Battery-Operated Smoke Detector Maintenance Log to be filed in the Life Safety Binder as a part of the facility's Preventive Maintenance Program. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. b) The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance	

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	and Director of Nursing at the exit conference. 3.1-19(b)		documentation is in place. **4) MONITORING CORRECTIVE ACTION**: a) The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is September 16, 2023.**	
K 0351 SS=D Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit			

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	sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. This deficient practice could affect 2 residents. Findings include: Based on observations and interview during a tour of the facility with the Administrator and Director of Nursing on 09/06/23 between 12:15 p.m. and 1:35 p.m., the sprinkler head in resident room 119 was missing an escutcheon and did not completely cover the hole around the sprinkler. Based on interview at the time of observation, the Administrator agreed the aforementioned area was missing an escutcheon. This finding was reviewed with the Administrator and Director of Nursing at the exit conference. 3.1-19(b)	K 0351	**K351** - It is the intent of the facility to ensure to maintain the ceiling construction in rooms in accordance with NFPA 13, Standard for the installation of sprinkler systems to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On September 7, 2023 a Certified Sprinkler Contractor/Maintenance Supervisor/designee installed the missing escutcheon ring on the sprinkler head in resident room 119 to meet set standards. The Administrator verified the installation on September 7, 2023. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. **3. MEASURES TO PREVENT REOCCURRENCE**: a. The Administrator will in-service the new Maintenance Supervisor/designee on September 29, 2023 on the	09/07/2023

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			requirement that ceiling mounted sprinkler locations must be maintained including the escutcheon ring installed to meet set standards. b. Maintenance Supervisor/designee will inspect all sprinkler heads monthly to ensure they are maintained and have the escutcheon ring installed as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction	

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			developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is September 7, 2023.**	
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, 7.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct	K 0353	**K353** – It is the intent of the facility to ensure to maintain automatic sprinkler systems in accordance with NFPA 25 to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On October 10, 2023 the	10/10/2023

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	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 "Sprinkler: Five Year Internal Pipe Inspection" documentation dated 09/07/22 during record review with the Administrator from 9:35 a.m. to 12:15 p.m. on 09/06/23, the inspection results stated 'Found rust scale inside of fire sprinkler piping and recommend that dry pipe fire sprinkler system be flushed'. Based on interview at the time of record review, the Administrator stated she searched through emails and produced a quote dated 08/16/23 and quote expiration date 11/30/22 for performing a complete dry pipe fire sprinkler system flush but no work had been scheduled or performed since 09/07/22. Prior to the exit conference, the Administrator provided a document dated 09/06/23 from the facility's sprinkler inspection vendor that stated 'scheduled to begin the full fire sprinkler system flush at the above listed property, on Tuesday October 10, 2023.' This finding was reviewed with the Administrator and Director of Nursing at the exit conference. 3.1-19(b)		facilities Certified Sprinkler Contractor will conduct the dry pipe fire sprinkler system flush that was noted on the 09/14/22 inspection report and documented the results to meet set standards. The Administrator will verify the work on October 10, 2023. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.The Administrator will in-service the new Maintenance Supervisor/designee on September 29, 2023 the requirement that the deficiencies noted on the sprinkler inspection report must be corrected and documented to meet set standards. 2.Maintenance Supervisor/designee will ensure deficiencies noted on the sprinkler inspection report are corrected as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance	

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			schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is October 10, 2023.**	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors			

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	to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	1. Based on observation and interview, the facility failed to ensure 1 of 48 resident room corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect approximately 2 residents. Findings include:	K 0363	**K363** – It is the intent of the facility to ensure resident room corridor doors are provided with a means suitable for keeping the door closed, has no impediment to closing, latching and will resist the passage of smoke and to ensure corridor doors are provided with a means suitable for keeping the	09/07/2023

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	Based on observation with the Administrator on 09/06/23 at 12:50 p.m., the corridor doors to resident room 126 did not latch into the frame when tested. Based on interview at the time of observation, the Administrator agreed that the door to resident room 126 did not latch into the frame and would need adjusting. The finding was reviewed with the Administrator and the Director of Nursing during the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of over 50 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 5 residents, staff and visitors in the vicinity of the Therapy room. Findings include: Based on observation after the entrance to the facility on 09/06/23 at 9:30 a.m. the corridor double doors serving as the entrance to the Therapy Room were propped in the fully open position with rubber wedges at the floor. Based on observation during a tour of the facility at 1:20 p.m. with the Administrator and Director of Nursing, the corridor double doors serving as entrance to Therapy were propped fully open by rubber wedges at the floor. Based on interview at the time of observation, the Administrator confirmed the corridor doors were propped in the fully open position with wedges placed on the floor. This finding was reviewed with the Administrator		door closed, have no impediments to closing, latching and will resist the passage of smoke to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On September 7, 2023 the Maintenance Supervisor/designee repaired the latching mechanism in the corridor door to resident room 126 so it would latch fully into the frame to meet set standards. The Administrator verified the repairs on September 7, 2023. b. On September 7, 2023 the Maintenance Supervisor/designee removed the wedges that were used to prop open the double doors serving as the entrance to the Therapy Room to meet set standards. The Administrator verified the work on September 7, 2023. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee inspected all corridor doors to ensure they latch fully into the frame and have no obstructions to closing and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. The Administrator will in-service the new Maintenance Supervisor/designee and all staff	

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	and Director of Nursing at the exit conference. 3.1-19(b)		on September 29, 2023 on the requirement that corridor doors must latch fully into the frame and have no obstructions to closing to meet set standards. b. Maintenance Supervisor/designee will inspect all corridor doors throughout the facility monthly to ensure they latch fully into the frame and have no obstructions to closing as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction	

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			developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is September 7, 2023.**	
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent 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			

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	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 a written record of weekly inspections for the generator was maintained for 2 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 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 residents, staff and visitors. Findings include: Based on record review with the Administrator on 09/06/23 from 9:35 a.m. to 12:15 p.m., documentation for the weeks of 09/26/22 and 10/24/22 weekly generator testing was not available for review. Based on an interview at the time of record review, the Administrator confirmed weekly generator testing was not documented on the aforementioned weeks. This finding was reviewed with the Administrator and Director of Nursing at the exit conference.	K 0918	**K918** – It is the intent of the facility to ensure a written record of weekly inspections for the generator is maintained for all 52 weeks to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. The Administrator will in-service the new Maintenance Supervisor/designee on September 29, 2023 on the requirement that a weekly test for all 52 weeks must be conducted on the emergency generator is required to meet set standards. b. On September 9, 2023 the Maintenance Supervisor/designee conducted the weekly emergency generator test and documented the results in the facilities Life Safety Binder to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. The Maintenance Supervisor/designee will ensure a	09/09/2023

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	3.1-19(b)		weekly emergency generator test is conducted for all 52 weeks and documented in the life safety binder to meet set standards. b. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is September 9, 2023.**	