STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155771	A. BUILDING -- B. WING	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE	1070 W JEFFERSON ST FRANKLIN, IN 46131

(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(s): 11/22/22 & 11/23/22 Facility Number: 001127 Provider Number: 155771 AIM Number: 200247220 At this Emergency Preparedness survey, Otterbein Franklin Senior Life Comm Res & Com Care was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 208 certified beds. At the time of the survey, the census was 136. Quality Review completed on 11/30/22 The requirement at 42 CFR Subpart 483.73 is NOT MET as evidenced by:	E 0000	The creation and submission of this Plan of Correction do not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or any violation of the regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post-survey review.	
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shannon Logan	Administrator	12/19/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155771	A. BUILDING -- B. WING	11/23/2022

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	§484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(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 the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency			

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	155771	A. BUILDING -- B. WING	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.			
	Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). In the Survey & Certification memo QSO: 19-06-ALL dated 02/01/19, the Centers for Medicare and Medicaid Services (CMS) updated Appendix Z of the State Operations Manual to reflect changes to add emerging infectious diseases to the definition of all-hazards approach and stated "Planning for using an all-hazards	E 0006	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient	12/16/2022

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	155771	A. BUILDING -- B. WING	11/23/2022

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	approach should also include emerging infectious disease (EID) threats. Examples of EIDs include Influenza, Ebola, Zika Virus and others". This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness Manual" documentation dated 11/07/21 with the Main Building Maintenance Manager and the Building Services Coordinator during record review from 9:00 a.m. to 12:45 a.m. on 11/22/22, a documented facility-based and community-based risk assessment addressing emerging infectious disease (EID) threats was not available for review. EID was not included in the current "Annex I: 2021 Summary: Hazard Vulnerability Assessment" for the facility. Based on interview at the time of record review, the Main Building Maintenance Manager agreed emergency preparedness program documentation did not address emerging infectious diseases (EID) as part of the facility-based and community-based risk assessment as mandated by the CMS Survey & Certification memo QSO: 19-06-ALL. This finding was reviewed with the Administrator, the Main Building Maintenance Manager and the Building Services Coordinator during the exit conference.		practice. The Kaiser-Permanente assessment (see attachment #1) for the facility has been completed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The Maintenance Manager was educated (see attachment #3) by the Administrator on the importance of developing and maintaining an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based, and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Kaiser-Permanente assessment for the facility and the Emergency Action Plan will be reviewed each quarter by the QA committee each quarter for four quarters and then annually thereafter.	

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	155771	A. BUILDING -- B. WING	11/23/2022

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			By what date the systemic changes for each deficiency will be completed? 12/16/2022	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set 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			

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	inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. 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.			

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	(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on record review, observation and interview; the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff and visitors. Findings include: a. Based on observations with the Main Building Maintenance Manager during a tour of the facility from 8:30 a.m. to 11:20 a.m. on 11/23/22, no battery-powered emergency lighting systems were noted at the emergency generator location which	E 0041	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient	02/23/2023

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	was located inside the facility. Based on interview at the time of the observations, the Main Building Maintenance Manager agreed no battery-powered emergency lighting systems were installed at the emergency generator location which was located inside the facility. b. Based on review of Workxhub "Monthly Emergency Generator Load Test (30 Min)" documentation for the most recent twelve month period with the Main Building Maintenance Manager and the Building Services Coordinator during record review from 9:00 a.m. to 12:45 a.m. on 11/22/22, monthly load testing documentation for the facility's diesel fired emergency generator for the most recent twelve month period was incomplete. The load percent achieved for the test or the loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer was not documented. Based on interview at the time of record review, the Main Building Maintenance Manager stated the facility changed how they keep generator testing documentation within the last two year period to the computer program entitled "Workxhub" which had not yet been updated to document the load percent achieved for a monthly load test and agreed monthly load testing documentation for the facility's diesel fired emergency generator for the most recent twelve month period was incomplete. c. Based on record review with the Main Building Maintenance Manager and the Building Services Coordinator during record review from 9:00 a.m. to 12:45 a.m. on 11/22/22, documentation of an annual fuel quality test for the diesel fired emergency generator was not available for review. Based on interview at the time of record review, the Main Building Maintenance Manager stated		practice. Immediate Action Taken: a) Emergency battery ordered 12/13/2022 (attachment #2) b) Monthly load test completed 12/9/2022 (attachment #3) c) Annual fuel quality test completed 1/24/2022 (attachment #4) Initial Audits: a) An Audit will be completed on all emergency battery lighting systems once installed. b) Audit completed on 12/9/2022 on the Emergency generator for load test. c) Audit completed on 1/24/2022 on annual fuel quality. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Once installation is completed, audits will be completed monthly by maintenance staff. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Any identified deficiencies will be corrected upon discovery and reviewed by the QA committee for further recommendation. **By what date the systemic changes for each deficiency will be completed?** 02/23/2023	

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	the facility has one diesel fired emergency generator and agreed documentation of an annual fuel quality test for the diesel fired emergency generator was not available for review. These findings were reviewed with the Administrator, the Main Building Maintenance Manager and the Building Services Coordinator during 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(s): 11/22/22 & 11/23/22 Facility Number: 001127 Provider Number: 155771 AIM Number: 200247220 At this Life Safety Code Survey, Otterbein Franklin Senior Life Comm Res & Com Care was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. Otterbein Franklin Senior Life Comm Res & Com Care consists of four separate but connected buildings constructed at four different times: Building 1, a NCC facility built in 1957, is a three story sprinklered building of Type I (332) construction with a basement; Building 2, built in	K 0000	The creation and submission of this Plan of Correction do not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or any violation of the regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post-survey review.	

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	1980 is a three story sprinklered building of Type I (332) construction with a basement; Building 3, built in 1992 is a one story sprinklered building of Type I (332) construction with a basement; and Building 4, built in 2000 is a three story sprinklered building of Type I (332) construction. Because all buildings are of the same type of construction, the facility was surveyed as one building. The facility has a fire alarm system with smoke detection in the corridors and all areas open to the corridor. In Building 2, 47 battery operated detectors were provided in resident rooms in Health Center 2 and Health Center 3. All other resident rooms in Building 2 are provided with hard wired smoke detectors. In Building 3 and Building 4, hard wired smoke detectors are installed in all resident rooms. The healthcare portion of the facility has a capacity of 208 and had a census of 136 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 11/30/22			
K 0225 SS=E Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Based on observation and interview, the facility failed to ensure items stored in 1 of 4 interior fire escape stairways would not interfere with egress. LSC 7.2.2.5.3.1 states open space within the exit enclosure shall not be used for any purpose that has the potential to interfere with egress. This deficient practice could affect over 10 residents, staff and visitors using the third floor exit stairwell	K 0225	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice.	12/16/2022

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	by Room 356 in Building 4. Findings include: Based on observations with the Main Building Maintenance Manager during a tour of the facility from 1:20 p.m. to 2:20 p.m. on 11/22/22, the exit stairwell on the third floor in Building 4 by Room 356 was marked as a facility exit. A wooden chair and a cart with oxygen supplies and one 'E' type oxygen cylinder were stored in the exit stairwell on the third floor landing. Based on interview at the time of observation, the Main Building Maintenance Manager agreed the aforementioned stairwell on the third floor in Building 4 was used for storage which could interfere with egress. This finding was reviewed with the Administrator, the Main Building Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b)		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. The wooden chair and cart were immediately removed upon identification on 11/22/2022. An audit was completed on all escape stairways on 11/23/2022. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All staff has been educated by the main building manager on the importance of keeping exit egresses clear of obstacles. (Attachment #5) Beginning 12/15/2022 audits will be initiated weekly by maintenance staff. (Attachment #6) **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Audits of the stairwells will be completed once a week for four weeks, then once a month for three months. The Maintenance Director will bring the audits to the QA meetings for review. After the	

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			initial audits are completed and 100% compliance has been achieved, the QA committee may discontinue the audits. **By what date the systemic changes for each deficiency will be completed?** 12/16/2022	
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 accordance with 7.9. 18.2.9.1, 19.2.9.1 1. Based on record review, observation and interview; the facility failed to document monthly and annual testing for all battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents,	K 0291	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. Main Building Maintenance Manager was educated by the Administrator on 12/12/2022, (Attachment #7) on the importance of Emergency Lighting, citing: Section 7.9.3.1.1 states testing of emergency	02/23/2023

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	155771	A. BUILDING 01 B. WING	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE	1070 W JEFFERSON ST FRANKLIN, IN 46131

(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
	staff and visitors. Findings include: Based on record review with the Main Building Maintenance Manager and the Building Services Coordinator from 9:00 a.m. to 12:45 a.m. on 11/22/22, monthly and annual battery operated light testing documentation for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Main Building Maintenance Manager and the Building Services Coordinator agreed monthly and annual functional testing documentation for battery operated lights located inside the facility for the most recent twelve month period was not available for review. Based on observations with the Main Building Maintenance Manager during a tour of the facility from 8:30 a.m. to 11:20 a.m. on 11/23/22, only one battery operated lighting system was noted in the facility which was attached to the exit sign by Room 2 in the Murphy's Special Care Area on the first floor in Building 3 which failed to illuminate when its respective test button was pushed multiple times. This finding was reviewed with the Administrator, the Main Building Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 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		lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery-powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Once light is received and installed, audits will be completed monthly by maintenance staff. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Any identified deficiencies will be	

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	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 10 residents, staff and visitors in the "Murphy's Special Care Area on the first floor in Building 3. Findings include: Based on observations with the Main Building Maintenance Manager during a tour of the facility from 8:30 a.m. to 11:20 a.m. on 11/23/22, only one battery operated lighting system was noted in the facility which was attached to the exit sign by Room 2 in the Murphy's Special Care Area on the first floor in Building 3 which failed to illuminate when its respective test button was pushed multiple times. Based on interview at the time of the observations, the Main Building Maintenance Manager 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, the Main Building Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b)		corrected upon discovery and reviewed by the QAPI committee for further recommendation. **By what date the systemic changes for each deficiency will be completed?** 02/23/2023	
K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in			

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	accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. Based on observation and interview, the facility failed to maintain protection of 2 of 4 interior stairwells. LSC 19.3.1 requires vertical openings shall be enclosed or protected in accordance with Section 8.6. LSC 8.6.1 requires every floor that separates stories in a building shall be constructed as a smoke barrier. LSC 8.6.5 states see 7.1.3.2.1 for enclosures of exits. LSC 7.1.3.2.1 states the separation shall have a minimum 1-hr fire resistance rating where the exit connects three stories or less. Fire doors assemblies are in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, Section 4.8.4.1 states the clearance under to bottom of of a door shall be a maximum of 3/4ths inch. This deficient practice could affect over 30 residents, staff and visitors. Findings include: a. Based on observations with the Main Building Maintenance Manager during a tour of the facility from 1:20 p.m. to 2:20 p.m. on 11/22/22, foam was being used to firestop one data cable penetration of the stairwell wall above the suspended ceiling above the stairwell door by Room 386 on the third floor in Building 2. The stairwell door was affixed with a 90-minute fire resistance rating label and latched into the door frame. Based on interview at the time of the observations, the Main Building Maintenance Manager stated he was not aware of the UL Listing or fire resistance rating of the foam used to firestop the penetration of the stairwell wall.	K 0311	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. Audit completed on all emergency stairwells on 11/23/2022. Please see before and after pictures (attachments #8, #9, #10) **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** After each contracted job, The Maintenance Manager will audit completion for any penetrated spots in the work area. (attachment #11) **How will the corrective action(s) be monitored to ensure the deficient practice**	12/16/2022

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	b. Based on observations with the Main Building Maintenance Manager during a tour of the facility from 8:30 a.m. to 11:20 a.m. on 11/23/22, two separate one inch square holes plus a three inch in diameter hole were noted in the stairwell wall above the suspended ceiling above the stairwell door by Room 248 on the second floor in Building 2. The stairwell door was affixed with a 90-minute fire resistance rating label and latched into the door frame. Based on interview at the time of the observations, the Main Building Maintenance Manager agreed the aforementioned holes in the stairwell wall did not maintain the fire resistance rating of the stairwell wall. This finding was reviewed with the Administrator, the Main Building Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b)		**will not recur, i.e., what quality assurance program will be put into place?** Any identified deficiencies will be corrected upon discovery and reviewed by the QAPI committee for further recommendation. **By what date the systemic changes for each deficiency will be completed?** 12/16/2022	
K 0345 SS=C 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 observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date information in accordance with the requirements of NFPA 101-	K 0345	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	12/16/2022

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	2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Main Building Maintenance Manager during a tour of the facility from 8:30 a.m. to 11:20 a.m. on 11/23/22, the date and the time of day for the main fire alarm control panel were incorrect. The display read the date as November 24, 2022 and the time of day as 9:56 a.m. at 10:55 a.m.. Based on interview at the time of the observations, the Main Building Maintenance Manager agreed the main fire alarm control panel did not display the correct date and the correct time of day. This finding was reviewed with the Administrator, the Main Building Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b)		**practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. Contractor programmed correct time and date into the Fire Alarm Panel on 12/8/2022. (attachment #12) **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** An audit will be completed after each fire drill to ensure accuracy of date and time. (attachment #13) **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The audit will be reviewed each month at QAPI for at least six months. After six months and 100% compliance, the QA committee may decide to stop the audits. **By what date the systemic changes for each deficiency**	

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			will be completed? 12/16/2022	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction in 2 of 75 rooms 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 over 10 residents, staff and visitors in the vicinity of resident sleeping Room 303 on the third floor in Building 2. Findings include:	K 0351	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?**	02/23/2023

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	Based on observations with the Main Building Maintenance Manager during a tour of the facility from 1:20 p.m. to 2:20 p.m. on 11/22/22, one of two ceiling mounted sprinklers in resident sleeping Room 303 on the third floor in Building 2 was missing its escutcheon. In addition, one of the ceiling mounted sprinklers in the Shower Room by Room 304 on the third floor in Building 2 was also missing its escutcheon. Based on interview at the time of the observations, the Main Building Maintenance Manager agreed the aforementioned ceiling mounted sprinkler locations were missing its escutcheon. This finding was reviewed with the Administrator, the Main Building Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b)		No other residents have been identified as having the potential to be affected by the alleged deficient practice. The Maintenance Manager educated by the Administrator (see attachment #14) on 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. 2 Escutcheons were ordered from Koorsen but the wrong size arrived. New ones are to arrive and be replaced by 12/23/2022 in Room 303 and the shower room by 304. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Once the installation has been completed, audits will be conducted weekly for four weeks, then continue random for one month and thereafter for three months. (attachment #15) **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Audits will be reviewed by the QA committee. Once initial audits have been completed, and 100% compliance has been met, the	

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			committee may decide to discontinue audits. **By what date the systemic changes for each deficiency will be completed?** 02/23/2023	
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 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			

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	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. Based on observation and interview, the facility failed to ensure 2 of over 15 corridor doors to resident sleeping rooms on the second floor in Building 4 would resist the passage of smoke. This deficient practice could affect over 15 residents, staff and visitors in the vicinity of Room A258 on the second floor in Building 4. Findings include: Based on observations with the Main Building Maintenance Manager during a tour of the facility from 8:30 a.m. to 11:20 a.m. on 11/23/22, a one inch gap was noted in between the face of the corridor door and the door stop on the door frame to resident sleeping room A258 and A260 on the second floor in Building 4 when the doors were in the fully closed and latched position and would not resist the passage of smoke. Based on interview at the time of the observations, the Main Building Maintenance Manager agreed the aforementioned corridor doors would not resist the passage of smoke. This finding was reviewed with the Administrator, the Main Building Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b)	K 0363	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. The Maintenance Manager was educated by the Administrator (see attachment #16) on Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas that 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	12/16/2022

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			required to resist the passage of smoke. Corridor doors and doors 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. The clearance between the bottom of the 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 lbs is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled is 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 the area or fire resistance of glass or frames in window assemblies. Gaps in doors A258 and A260 were repaired on 12/16/2022. (Attachments #17 and #18) Audit of doors for gaps completed by maintenance on 11/23/2022.	

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			What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Audits will be conducted weekly for four weeks and then monthly for three months. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Audit will be reviewed by the QA committee. Once initial audit is completed and 100% compliance is met, the committee may choose to discontinue the audit. **By what date the systemic changes for each deficiency will be completed?** 12/16/2022	
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			

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OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE	1070 W JEFFERSON ST FRANKLIN, IN 46131

(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
	system in REMARKS. Based on observation and interview, the facility failed to ensure 2 of 10 smoke barrier walls were protected to maintain the fire resistance of the smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect over 40 residents, staff and visitors. Findings include: a. Based on observations with the Main Building Maintenance Manager during a tour of the facility from 1:20 p.m. to 2:20 p.m. on 11/22/22, foam was being used to firestop one hole for multiple data cables which penetrated the smoke barrier wall above the suspended ceiling above the corridor door set in the third floor corridor wall separating Building 2 from Building 4. Each door in the corridor door set was affixed with a 90-minute fire resistance rating label and latched into the door frame. Based on interview at the time of the observations, the Main Building Maintenance Manager stated he was not aware of the UL listing or fire resistance rating of the foam used to firestop the penetration of the smoke barrier wall. b. Based on observations with the Main Building Maintenance Manager during a tour of the facility from 8:30 a.m. to 11:20 a.m. on 11/23/22, a six inch by 4 inch hole for the passage of two copper pipes was noted in the smoke barrier wall above the suspended ceiling above the corridor door set in the second floor corridor wall separating Building 2 from Building 4. A separate one inch hole was also noted above the suspended ceiling in the smoke barrier wall. Two layers of 5/8ths inch thick drywall was noted on each side of the smoke barrier wall and each door in the corridor	K 0372	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. Audit completed on all emergency stairwells on 11/23/2022. Please see before and after pictures (attachments #8, #9, #10). **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** After each contracted job, The Maintenance Manager will audit for any penetrated spots in the work area. (attachment #11) **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Any identified deficiencies will be corrected upon discovery and reviewed by the QAPI committee	12/16/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155771	A. BUILDING 01 B. WING	11/23/2022

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	door set was affixed with a 90-minute fire resistance rating label and latched into the door frame. Based on interview at the time of the observations, the Main Building Maintenance Manager agreed the aforementioned openings in the smoke barrier wall were not firestopped to maintain the fire resistance of the smoke barrier. This finding was reviewed with the Administrator, the Main Building Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b)		for further recommendation. **By what date the systemic changes for each deficiency will be completed?** 12/16/2022	
K 0541 SS=D Bldg. 01	NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chu Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with			

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	19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 Based on observation and interview, the facility failed to ensure 1 of 1 laundry chute rooms was maintained in accordance with NFPA 82. NFPA 82, Standard on Incinerators and Waste and Linen Handling Systems and Equipment, 2009 Edition, Section 5.2.3.2.2 states the bottom of a linen chute shall be protected by a listed automatic closing or self closing door in accordance with Section 5.2.3.1. Section 5.2.3.1.3 states openings shall be as follows: (1) 1 1/2 fire resistance rating for 2-hour rated enclosures. (2) 1-hour fire resistance rating for 1-hour rated enclosures. This deficient practice could affect over two staff in the basement. Findings include: Based on observations with the Main Building Maintenance Manager during a tour of the facility from 8:30 a.m. to 11:20 a.m. on 11/23/22, a one foot by one foot hole was noted in the ceiling of the laundry chute room in the basement. Based on interview at the time of the observations, the Main Building Maintenance Manager stated the facility had been doing plumbing repairs in the room which were now completed but agreed the ceiling of the laundry chute room was not enclosed with a minimum of 1-hour fire resistance rating. This finding was reviewed with the Administrator, the Main Building Maintenance Manager and the Building Services Coordinator during the exit conference.	K 0541	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The alleged deficient areas were repaired 11/24/2022. Please see before and after photos (attachment #19) After each contracted job, the Maintenance Manager will audit completion for any penetrated spots in the work area. (attachment #11) **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality**	12/16/2022

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	3.1-19(b)		**assurance program will be put into place?** Any identified deficiencies will be corrected upon discovery and reviewed by the QAPI committee for further recommendation. **By what date the systemic changes for each deficiency will be completed?** 12/16/2022	
K 0761 SS=F Bldg. 01	Based on record review and interview, the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door	K 0761	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. Initial door inspection of smoke and fire doors completed on 12/15/2022. (attachment #20) **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Audits will be completed through	12/16/2022

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	assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, Section 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Main Building Maintenance Manager and the Building Services Coordinator from 9:00 a.m. to 12:45 a.m. on		Worxhub by maintenance staff annually. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Any identified deficiencies will be corrected upon discovery and reviewed by the QAPI committee for further recommendation. **By what date the systemic changes for each deficiency will be completed?** 12/16/2022	

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	11/22/22, annual inspection documentation of fire door assemblies in the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Main Building Maintenance Manager stated the facility had started to perform fire door inspections and testing but did not complete it due to maintenance staff turnover and agreed annual inspection documentation of fire door assemblies in the facility within the most recent twelve month period was not available for review. This finding was reviewed with the Administrator, the Main Building Maintenance Manager and the Building Services Coordinator 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)			

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	Based on record review, observation 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 pipe gas system not be operational. Findings include: Based on record review with the Main Building Maintenance Manager and the Building Services Coordinator from 9:00 a.m. to 12:45 a.m. on 11/22/22, annual inspection documentation for the facility's piped gas systems within the most recent twelve month period was not available for review. Review of "Certification of the Medical Gas Systems" documentation dated September 10, 2000 indicated the most recent inspection documentation for the facility's piped gas systems was more than 20 years old. Based on interview at the time of record review, the Main Building Maintenance Manager agreed annual inspection documentation for the facility's piped gas systems within the most recent twelve month period was not available for review. Based on observations with the Main Building Maintenance Manager during a tour of the facility from 1:20 p.m. to 2:20 p.m. on 11/22/22 and from 8:30 a.m. to 11:20 a.m. on 11/23/22, the facility has piped gas systems serving resident sleeping rooms on the second and third floor of Building 2. This finding was reviewed with the Administrator, the Main Building Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b)	K 0907	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. Inspector certifying oxygen on 12/16/2022. (attachment #21) **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Annual inspection set up in Worxhub for maintenance staff to ensure completion. (attachment #22) **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Any identified deficiencies will be corrected upon discovery and reviewed by the QAPI committee for further recommendation. **By what date the systemic changes for each deficiency**	12/16/2022

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			will be completed? 12/16/2022	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review and interview, the facility failed to ensure documentation of electrical outlet receptacle testing for all resident sleeping rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not	K 0914	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the**	02/23/2023

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	exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all residents. Findings include: Based on record review with the Main Building Maintenance Manager and the Building Services Coordinator from 9:00 a.m. to 12:45 a.m. on 11/22/22, annual electrical receptacle inspection and testing documentation for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Main Building Maintenance Manager stated the facility had started to perform electrical receptacle inspection and testing but did not complete it due to maintenance staff turnover and agreed electrical receptacle inspection and testing documentation within the most recent twelve month period was not available for review. This finding was reviewed with the Administrator, the Main Building Maintenance Manager and the		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. Initial audit of all receptacles to be completed by 12/31/2022. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Annual audit created in Worxhub for preventative maintenance to be completed by maintenance staff. (attachment #23) **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Any identified deficiencies will be corrected upon discovery and reviewed by the QAPI committee for further recommendation. **By what date the systemic changes for each deficiency will be completed?** 02/23/2023	

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	Building Services Coordinator during the exit conference. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent 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			

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	consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator locations inside the facility was provided with task battery backup lights. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition at section 7.3.1 requires the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on observations with the Main Building Maintenance Manager during a tour of the facility from 8:30 a.m. to 11:20 a.m. on 11/23/22, no battery-powered emergency lighting systems were noted at the emergency generator location which was located inside the facility. Based on interview at the time of the observations, the Main Building Maintenance Manager agreed no battery-powered emergency lighting systems were installed at the emergency generator location which was located inside the facility.	K 0918	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. Immediate Action Taken: a) Emergency battery ordered 12/13/2022 (attachment #2) b) Monthly load test completed 12/9/2022 (attachment #3) c) Annual fuel quality test completed 1/24/2022 (attachment #4) Initial Audits: a) An Audit will be completed on all emergency battery lighting systems once installed. b) Audit completed on 12/9/2022 on the Emergency generator for load test. c) Audit completed on 1/24/2022 on annual fuel quality. **What measures will be put into place and what systemic changes will be made to**	02/23/2023

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	This finding was reviewed with the Administrator, the Main Building Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to document emergency generator monthly load testing for the most recent 12 month period to meet the requirements of NFPA 110, Standard for Emergency and Standby Powers Systems, 2010 Edition, Chapter 8.4.2. Section 8.4.2 states diesel generator sets shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Workxhub "Monthly Emergency Generator Load Test (30 Min)" documentation for the most recent twelve month		**ensure that the deficient practice does not recur?** Once installation is completed, audits will be completed monthly by maintenance staff. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Any identified deficiencies will be corrected upon discovery and reviewed by the QAPI committee for further recommendation. **By what date the systemic changes for each deficiency will be completed?** 02/23/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155771	A. BUILDING 01 B. WING	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	period with the Main Building Maintenance Manager and the Building Services Coordinator during record review from 9:00 a.m. to 12:45 a.m. on 11/22/22, monthly load testing documentation for the facility's diesel fired emergency generator for the most recent twelve month period was incomplete. The load percent achieved for the test or the loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer was not documented. Based on interview at the time of record review, the Main Building Maintenance Manager stated the facility changed how they keep generator testing documentation within the last two year period to the computer program entitled "Workxhub" which had not yet been updated to document the load percent achieved for a monthly load test and agreed monthly load testing documentation for the facility's diesel fired emergency generator for the most recent twelve month period was incomplete. This finding was reviewed with the Administrator, the Main Building Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b) 3. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for the facility's diesel-powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8.			

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	NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Main Building Maintenance Manager and the Building Services Coordinator during record review from 9:00 a.m. to 12:45 a.m. on 11/22/22, documentation of an annual fuel quality test for the diesel fired emergency generator was not available for review. Based on interview at the time of record review, the Main Building Maintenance Manager stated the facility has one diesel fired emergency generator and agreed documentation of an annual fuel quality test for the diesel fired emergency generator was not available for review. This finding was reviewed with the Administrator, the Main Building Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b)			
K 0920 SS=E 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 the patient care vicinity may not be used for			

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	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 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the second floor Building 2 Beauty Shop near room 2223. Findings include: Based on observations with the Main Building Maintenance Manager during a tour of the facility from 8:30 a.m. to 11:20 a.m. on 11/23/22, a hair	K 0920	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. Beautician was educated 11/24/2022 by Maintenance Manager on power and extension cords. (attachment #24) **What measures will be put into place and what systemic changes will be made to**	12/16/2022

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	dryer was plugged into a power strip on the floor in the second floor Building 2 Beauty Shop near room 2223. Based on interview at the time of the observations, the Main Building Maintenance Manager agreed a power strip was being used as a substitute for fixed wiring at the aforementioned location. 3.1-19(b)		**ensure that the deficient practice does not recur?** Audit to be conducted weekly for four weeks and then random audits once a month for three months for extension cord use. (attachment #25) **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Any identified deficiencies will be corrected upon discovery and reviewed by the QAPI committee for further recommendation. **By what date the systemic changes for each deficiency will be completed?** 12/16/2022	