STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155303	A. BUILDING -- B. WING	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOOD SAMARITAN SOCIETY SHAKAMAK RETIREMENT COMM	800 E OHIO ST JASONVILLE, IN 47438

(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: 01/31/24 Facility Number: 000200 Provider Number: 155303 AIM Number: 100367980 At this Emergency Preparedness survey, Good Samaritan Society Shakamak Retirement Community was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 60 certified beds, with a current census of 38. Quality Review completed on 02/05/24	E 0000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual. *February 15, 2024* *To : Long Term Care Director* *Attention Brenda Buroker* *Indiana State Department of Health* *2 North Meridian Street,* *Indianapolis, IN 46204* *Re: Good Samaritan Society Shakamak Retirement Comm* *CCN/Provider Number: 155303* *AIM Number: 100367980* *Facility ID: 000200* *This letter comes to you as a*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deborah Davis	HFA	02/14/2024

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

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			request for paper compliance to the facility's Life Safety Code Recertification and Emergency Preparedness Survey dated January 31st 2024. *The facility received 6 deficiencies which were low scope and severity in nature.* *The facility feels it has corrected the deficiencies and submits to the department the following proof of corrections.* *Please see the uploaded corrections.* *Sincerely,* *Deborah E Davis, Health Facility Administrator* *812-665-2226*	
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			

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

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	552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October			

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	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 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 records review with the Maintenance Supervisor on 01/31/24 between 10:00 a.m. and 12:50 p.m., documentation for the diesel generator three-year exercise under load required by LSC and NFPA 110 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated he was unable to locate the missing documentation at the time of the survey. This finding was reviewed with the Administrator and Maintenance Supervisor at the exit conference.	E 0041	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual. E 041 Hospital CAH and LTC Emergency Power Corrective actions: The facility did conduct a 36 Monthly Emergency Generator test, it was done timely on July 21,2022. The facility found the record of this 3ph 4 hour continuous test filed in a 2022 Emergency Preparedness binder, unfortunately the surveyor had already completed the Life Safety Code survey and had left the	02/16/2024

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			facility. See attached 36 month Emergency Generator test results, dated 7-21-2022 Other residents having the potential to be affected: Residents in the facility could have had the potential to be affected, however was not, due to the fact that the test was done timely and properly. Systemic changes implemented: The Facility will continue to comply with Life Safety Code and NFPA 110 requirements, The Maintenance Director will ensure that all documentation is maintained in a manner that can be easily obtained and shows when it was inspected timely. A calendar will be maintained by the Maintenance Director that identifies the last date in which the requirement for the 3ph-36 month generator 4 hour continuous run test was conducted and identify when the testing should be conducted in the future. Monitoring of the corrective action: The Administrator or designee will	

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			conduct, along with the Maintenance Director, monthly audits of the Preventative maintenance for regulation E 041 calendar and identify when the test should be conducted to ensure timeliness and results are obtained with the proper information in written form of the test, placed in a secured area within the facility and assessable for review. Inspection calendar will be reviewed monthly for 4 months until QAPI committee review has deemed that substantial compliance has been obtained. Completion date : 2/16/2024	
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: 01/31/24 Facility Number: 000200 Provider Number: 155303	K 0000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it	

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	AIM Number: 100367980 At this Life Safety Code survey, Good Samaritan Society Shakamak Retirement Community 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 one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 60 and had a census of 38 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except two garages used for facility storage and maintenance. Quality Review completed on 02/05/24		is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual. *February 15, 2024* *To : Long Term Care Director* *Attention Brenda Buroker* *Indiana State Department of Health* *2 North Meridian Street,* *Indianapolis, IN 46204* *Re: Good Samaritan Society Shakamak Retirement Comm* *CCN/Provider Number: 155303* *AIM Number: 100367980* *Facility ID: 000200* *This letter comes to you as a request for paper compliance to the facility's Life Safety Code Recertification and Emergency Preparedness Survey dated January 31st 2024.* *The facility received 6 deficiencies which were low scope and severity in nature.* *The facility feels it has corrected the deficiencies and submits to the department the following proof of corrections.*	

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			Please see the uploaded corrections. *Sincerely,* *Deborah E Davis, Health Facility Administrator* *812-665-2226*	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in 1 of 4 corridors within the facility. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the	K 0211	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not substantial compliance with Federal requirements of participation, this	02/16/2024

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	following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect approximately 10 residents, 4 staff and 2 visitors. Findings include: Based on observation made with the Maintenance Supervisor on 01/31/24 at 1:10 p.m. during a tour the facility, there was a small three drawer plastic storage bin with personal protective equipment (P.P.E.) stored in the corridor immediately outside resident room #203. This bin was not on wheels. Based on interview with the Maintenance Supervisor at the time of the observation, he confirmed the plastic storage bin in the corridor was not on wheels. This finding was reviewed with the Administrator and Maintenance Supervisor at the exit conference. 3.1-19(b)		response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual. K 211 Means of Egress - General Corrective actions: On 1/31/24 the facility immediately placed wheels on the PPE bin, per walking rounds, other PPE bins were observed to have wheels in place for ease in moving the bins for means of egress in case of emergency. See attached picture showing correction Other residents having the potential to be affected: Residents in the facility have the potential to be affected. Systemic changes implemented: The facility will ensure that wheeled equipment does not	

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			reduce the clear unobstructed corridor width to less than 60 inches, the wheeled equipment can be relocated easily during a fire or similar emergency and is limited to equipment and carts in use, medical emergency equipment not in use, patient lift and transport equipment. Preventative maintenance daily rounds and guardian angel rounds will ensure means of egress is maintained. Re-education of the facility staff has been accomplished. Monitoring of the corrective action: The Maintenance Director and/or the Interdisciplinary team will monitor and assist in maintaining the proper means of egress, audits will occur 5 times weekly during random rounding times for 3 weeks, then weekly for 4 weeks. Audit findings will be discussed during clinical care meetings until QAPI committee review has audits and 100 % compliance has been met and deemed that substantial compliance has been obtained. Completion date : 2/16/2024	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an			

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	automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of over 5 hazardous areas, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 5 residents, as well as staff and visitors. Findings include: Based on observation during a tour of the facility with the Maintenance Supervisor on 01/31/24 at	K 0321	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the	02/16/2024

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	1:35 p.m., Room #403, greater than 50 square feet, contained a number of combustible items such as plastic trashcans and 20 or more cardboard boxes containing Covid tests. The corridor door to this room did not self-close and latch into the door frame. Based on interview at the time of observation, the Maintenance Supervisor confirmed Room #403 being used for storage was greater than 50 square feet and the corridor door did not self close and latch. This finding was reviewed with the Administrator and Maintenance Supervisor at the exit conference. 3.1-19(b)		purposes of any allegation that the facility is not substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual. K 321 Hazardous Areas - Enclosure Corrective actions: On 2/7/24 the facility had a self-closing device and door latch added to the door frame of Rm 403 which is being used as a storage area, no other areas were identified during the survey and during subsequent preventative maintenance rounds. See attached picture showing correction Other residents having the potential to be affected: Residents in the facility have the potential to be affected. Systemic changes implemented: The facility will ensure that per Preventative maintenance rounds, hazardous areas are protected by	

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			a automatic fire extinguishing system and doors shall have a properly working self-closing device and door latch in place. Any need of repairs or installation of self-closure door devices or door latches should be communicated to the Maintenance department and copied to the Administrator. Re-education of the facility staff has been accomplished. Monitoring of the corrective action: The Maintenance Director and/or his designee will monitor and assist in monitoring hazardous areas and immediate report of any need for or issues with self-closing door devices or door latches, audits will occur 5 times weekly during random rounding times for 3 weeks, then weekly for 4 weeks. Audit findings will be discussed during clinical care meetings until QAPI committee review has audits and 100 % compliance has been met and deemed that substantial compliance has been obtained. Completion date : 2/16/2024	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for			

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GOOD SAMARITAN SOCIETY SHAKAMAK RETIREMENT COMM	800 E OHIO ST JASONVILLE, IN 47438

(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
	Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			
	Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen fire suppression system was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices. Hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect staff in the kitchen. Findings include: Based on record review with the Maintenance Supervisor at 10:50 a.m. on 01/31/24, the most	K 0324	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual.	02/16/2024

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	recent semiannual kitchen fire suppression system inspection was conducted on 10/24/2023. Inspection documentation of the suppression system six months prior was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated there was no additional kitchen fire suppression system inspection documentation available to review at the time of the survey. This finding was reviewed with the Administrator and Maintenance Supervisor at the exit conference. 3.1-19(b)		K 324 Cooking Facilities Corrective actions: On 2/1/2024 a Semi-Annual hood suppression inspection was conducted. No issues were noted during the inspection. See attached Semi-Annual Hood Inspection report. Other residents having the potential to be affected: Residents in the facility have the potential to be affected. Systemic changes implemented: The facility did obtain a new company to conduct and provide the facility with a written copy of the semi-annual hood inspection. The new company has provided service and timely testing of the kitchens' hood suppression system in accordance with NFPA 96 and satisfying K tag 324. The kitchen hood suppression system will be inspected timely, a calendar will be maintained by the Maintenance Director that	

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			identifies what month the inspections should take place in order to be in compliance with NFPA 96 regulation, a copy will be shared with the Administrator. The facility Maintenance Director will maintain proper records of the sprinkler system testing in a secure location and have them readily available for review. Monitoring of the corrective action: The Administrator or designee will conduct, along with the Maintenance Director, audits of the calendar specifying any inspections listed as needing to be conducted in a timely manner, their results are obtained with the proper information received in written form and will be placed in a secured area within the facility and assessable for review. Inspection calendar will be reviewed monthly for 4 months until QAPI committee review has deemed that substantial compliance has been obtained. Completion date : 2/16/2024	

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K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. 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. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that	K 0353	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations	02/16/2024

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	waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the quarterly sprinkler system inspection records on 01/31/24 at 11:00 a.m. with the Maintenance Supervisor present, there was no quarterly sprinkler system inspection report available for the first quarter (January, February, March) of 2023. The sprinkler system inspection reports were dated 12/29/23, 10/24/23 and 06/30/23. During an interview at the time of record review, the Maintenance Supervisor stated they had changed sprinkler inspection vendors and confirmed there was no written documentation available at the time of the survey to show the sprinkler system had been inspected during the first quarter of 2023. This finding was reviewed with the Administrator and Maintenance Supervisor at the exit conference. 3.1-19(b)		Manual. K 353 Sprinkler System Maintenance and Testing Corrective actions: On 2/1/2024 the sprinkler system components were inspected and tested. No issues were noted during the inspection. See attached Quarterly Sprinkler Inspection report. Other residents having the potential to be affected: Residents in the facility have the potential to be affected. Systemic changes implemented: The facility did obtain a new company to inspect and test the facility's' sprinkler system components and provide the facility with a written copy of the inspection of the sprinkler system in 2023. The new company has provided service and timely testing of the sprinkler system in accordance with NFPA 25 and satisfying K tag 353. The sprinkler system will be inspected timely, a calendar will be maintained by the	

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			Maintenance Director that identifies what month the inspections should take place in order to be in compliance with NFPA 25 regulation, a copy will be shared with the Administrator. The facility Maintenance Director will maintain proper records of the sprinkler system testing in a secure location and have them readily available for review. Monitoring of the corrective action: The Administrator or designee will conduct, along with the Maintenance Director, monthly audits of the Sprinkler Inspection calendar and contact the Inspection company to ensure timely inspections are conducted and results are obtained with the proper information received in written form, placed in a secured area within the facility and assessable for review. Inspection calendar will be reviewed monthly for 4 months until QAPI committee review has deemed that substantial compliance has been obtained Completion date : 2/16/2024	

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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 consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110,			

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	NFPA 111, 700.10 (NFPA 70) Based on record review, observation, and interview; the facility failed to document 36-month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff, and visitors in the main building (Building 01). Findings include: Based on records review with the Maintenance Supervisor on 01/31/24 between 10:00 a.m. and 12:50 p.m., documentation for the diesel generator three-year exercise under load for four continuous hours was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated the facility has a 35kW diesel generator and he was unable to locate the 36-month generator testing documentation at the time of the survey.	K 0918	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual. K 918 Electrical Systems – Essential Electric System Maintenance and Testing Corrective actions: The facility did conduct a 36 Monthly Emergency Generator test, it was done timely on July 21,2022. The facility found the record of this 3ph 4-hour continuous test filed in a 2022 Emergency Preparedness binder, unfortunately the surveyor had already completed the Life Safety Code survey and had left the facility. See attached 36 month	02/16/2024

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	This finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		Emergency Generator test results, dated 7-21-2022 Other residents having the potential to be affected: Residents in the facility could have had the potential to be affected, however was not, due to the fact that the test was done timely and properly. Systemic changes implemented: The Facility will continue to comply with Life Safety Code and NFPA 99 and110 requirements, The Maintenance Director will ensure that all documentation is maintained in a manner that can be easily obtained and shows when it was inspected timely. A calendar will be maintained by the Maintenance Director that identifies the last date in which the requirement for the 3ph-36-month generator 4 hour continuous run test was conducted and identify when the testing should be conducted in the future. Monitoring of the corrective action: The Administrator or designee will conduct, along with the Maintenance Director, monthly audits of the Preventative	

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			maintenance for regulation K 918 calendar and identify when the test should be conducted to ensure timeliness and results are obtained with the proper information in written form of the test, placed in a secured area within the facility and assessable for review. Inspection calendar will be reviewed monthly for 4 months until QAPI committee review has deemed that substantial compliance has been obtained. Completion date : 2/16/2024	