STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155607	A. BUILDING -- B. WING	05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BETHEL MANOR	6015 KRATZVILLE RD EVANSVILLE, IN 47710

(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 Dates: 05/03/23 and 05/04/23 Facility Number: 000436 Provider Number: 155607 AIM Number: 100275120 At this Emergency Preparedness survey, Bethel Manor was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 75 certified beds. At the time of the survey, the census was 61. Quality Review completed on 05/11/23 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective June 2, 2023 to the annual licensure survey conducted May 4, 2023. We respectfully request a paper compliance/desk review.	
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Morgan Branning	Administrator	05/25/2023

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

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

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	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all residents in the facility. Findings include: Based on review of the Emergency Preparedness Program on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Administrator and Maintenance Coordinator present, the facility did provide an emergency preparedness manual, however, it has not been reviewed and updated during the past twelve months. The most recent date of review provided was August 2020. Based on interview at the time of review, the Administrator said the Emergency Preparedness Program has not been reviewed and updated within the past twelve months. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23.	E 0004	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified to be affected by the cited deficient practice. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected, however, none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The IDT met and completed the update of the Emergency Preparedness Plan. Monthly meetings were planned with Maintenance Coordinator and Administrator to ensure the Emergency Preparedness Plan is the most up to date. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to track meetings to update the Emergency Preparedness Plan as an IDT. This tool will be completed by the Administrator or designee, monthly for 3 months, then quarterly for three quarters. Any ideas identified through this audit will be immediately corrected. The	06/02/2023

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			outcome of this tool will be reviewed the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed. An additional tool will be kept in the Emergency Preparedness Plan Binder was developed to capture the necessary changes to the Emergency Preparedness Plan when changes occur outside of the annual review. This log will track the annual review update to ensure compliance.	
E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.			

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	*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this			

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	section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: Based on review of the Emergency Preparedness Program on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Administrator and Maintenance Coordinator present, there was documentation in the plan for facility policies and procedures, however the policies and procedures have not been reviewed by the facility within the most recent twelve month period. The most recent date of review provided was August 2020. Based on interview at the time of review, the Administrator said the Emergency Preparedness Program's policies and procedures has not been reviewed and updated within the past twelve months. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23.	E 0013	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified to be affected by the cited deficient practice. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected, however, none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The IDT met and completed the update of the Emergency Preparedness Policies and Procedures. Monthly meetings were planned with Maintenance Coordinator and Administrator to ensure the Emergency Preparedness Plan is the most up to date. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has	06/02/2023

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			been developed to capture the necessary changes to the Emergency Preparedness Plan when changes occur outside of the annual review. This log will track the annual review update to ensure compliance. This tool will be completed by the Administrator or designee, monthly for three months, then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility	E 0029	***The corrective action taken for***	06/02/2023

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	failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Program on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Administrator and Maintenance Coordinator present, the facility's emergency preparedness plan provided did include a plan to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws, however the communication plan has not been reviewed by the facility within the most recent twelve month period. The most recent date of review provided was August 2020. Based on interview at the time of review, the Administrator said the Emergency Preparedness Program's communication has not been reviewed and updated within the past twelve months. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23.		***those residents found to be affected by the deficient practice include:*** No specific residents were identified to be affected by the cited deficient practice. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected, however, none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The IDT met and updated Communication Plan. Monthly meetings were planned with Maintenance Coordinator and Administrator to ensure the Emergency Preparedness Plan is the most up to date. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to capture the necessary changes to the Emergency Preparedness Plan when changes occur outside of the annual review. This log will track the annual review update to ensure compliance. This tool will be completed by the Administrator or designee, monthly for three months, then quarterly for three quarters. Any areas identified	

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			through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.			

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	*[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and			

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	orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Program on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Administrator and Maintenance Coordinator present, there was documentation available to show the facility had an emergency preparedness training and testing program, however the training and testing program has not been reviewed by the facility within the most recent twelve month period. The most recent date of review provided was August 2020. Based on interview at the time of review, the Administrator said the Emergency Preparedness Program's training and testing program has not been reviewed and updated within the past twelve months. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23.	E 0036	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified in the survey findings. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected, however, none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The IDT met and updated Emergency Preparedness Training and Testing Plan. Monthly meetings were planned with Maintenance Coordinator, Human Resources, and Administrator to ensure the Emergency Preparedness Plan is the most up to date. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to capture the necessary changes to the Emergency Preparedness Plan when changes occur outside of the annual review. This log will track the annual review update to ensure compliance. This tool will	06/02/2023

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			be completed by the Administrator or designee, monthly for three months, then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed	
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			

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	structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain 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			

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	155607	A. BUILDING -- B. WING	05/04/2023

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	announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). Main Building 1. Based on record review and interview, the	E 0041	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified in the survey findings. ***Other residents that have the potential to be affected have been identified by:***	06/02/2023

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	facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service 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 (Load Bank Test) 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 occupants in the facility. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, the monthly load percentage for the diesel powered generator was documented less than 30% during the past 12 month period. Based on interview at the time of record review, the Maintenance Coordinator acknowledged the generator ran under load on a monthly basis but does not achieve 30% of the name plate rating. Additionally, the Maintenance Coordinator acknowledged a load bank test for the generator		All residents have the potential to be affected, however, none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The Maintenance Coordinator contacted generator company and a load bank test was completed on 5/17/2023 and a fuel sample was sent out. The load bank test will have to be completed annually due to the inability to meet the 30% threshold. A timeframe for the cool down period was added to the monthly maintenance check list. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** No further monitoring was deemed necessary, the monthly maintenance checks will ensure compliance. A reminder program is in the process of being integrated to ensure compliance with contracted companies to ensure compliance.	

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had not occurred within the past 12 months. The most recent diesel generator load bank test was dated 04/08/22.

This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23.

2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 110, 6.4.2.1.5.9 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, staff and visitors.

Findings include:

Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m., and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, there was documentation on the generator monthly load test log for a cool down period after the load test, however, it was with a check mark or "yes" only. A time frame

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	was not included. Based on interview at the time of record review, the facility Maintenance Coordinator said the cool down time for the generator was at least 5 minutes, but agreed the check mark or yes was not adequate. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 diesel powered generators. 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. 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, as well as staff and visitors. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, there was documentation of an annual generator inspection dated 01/09/23, however, there was no documentation of an annual fuel quality test for the diesel generator available for review. Based on interview at the time of record review, the Maintenance Coordinator stated the facility does have a diesel generator but after having spoken with the			

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	facility's generator inspection vendor it was determined that a fuel sample has not been taken within the past 12 month period. The most recent fuel sample test was performed on 04/20/22. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 4. Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, the facility could only provide documentation of an invoice of the four hour test of the emergency generator conducted on 09/02/22. The information and results of the four hour test were not available for review. This was confirmed by the Maintenance Coordinator at the time of record review.			

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	This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. Cottage House 1. Based on record review and interview, the facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service 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 (Load Bank Test) 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 occupants in the facility. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, the monthly load percentage for the diesel powered generator was documented less than 30% during the past 12 month period.			

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	Based on interview at the time of record review, the Maintenance Coordinator acknowledged the generator ran under load on a monthly basis but does not achieve 30% of the name plate rating. Additionally, the Maintenance Coordinator acknowledged a load bank test for the generator had not occurred within the past 12 months. The most recent diesel generator load bank test was dated 03/31/22. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 110, 6.4.2.1.5.9 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 05/03/23 between 9:30			

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	a.m. and 3:30 p.m., and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, there was documentation on the generator monthly load test log for a cool down period after the load test, however, it was with a check mark or "yes" only. A time frame was not included. Based on interview at the time of record review, the facility Maintenance Coordinator said the cool down time for the generator was at least 5 minutes, but agreed the check mark or yes was not adequate. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 diesel powered generators. 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. 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, as well as staff and visitors. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, there was documentation of an annual generator inspection dated 01/09/23,			

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	however, there was no documentation of an annual fuel quality test for the diesel generator available for review. Based on interview at the time of record review, the Maintenance Coordinator stated the facility does have a diesel generator but after having spoken with the facility's generator inspection vendor it was determined that a fuel sample has not been taken within the past 12 month period. The most recent fuel sample test was performed on 03/31/22. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 4. Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, the facility could only provide documentation of an invoice of the four			

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	hour test of the emergency generator conducted on 09/02/22. The information and results of the four hour test were not available for review. This was confirmed by the Maintenance Coordinator at the time of record review. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23.			
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 Dates: 05/03/23 and 05/04/23 Facility Number: 000436 Provider Number: 155607 AIM Number: 100275120 At this Life Safety Code survey, Bethel Manor 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 with a walkout lower level was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and in all resident sleeping rooms. This facility has a capacity of 63 and had a census	K 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective June 2, 2023 to the annual licensure survey conducted May 4, 2023. We respectfully request a paper compliance/desk review.	

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	of 55 at the time of this survey. The total capacity of both buildings was 75 and had a census of 61 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except three detached wood sheds used for facility storage. Quality Review completed on 05/11/23			
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to maintain the walking surface for 1 of 7 exit discharge areas. This deficient practice could affect at least 12 residents, as well as staff and visitors. Findings include: Based on observations on 05/04/23 between 11:45 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Coordinator, the outside exit sidewalk from the lower level north Ivy Unit courtyard had two, two inch wide cracks approximately five feet long in front of the exit gate to the public way. There was also a half inch to one inch level change between the cracks. The cracks and level changes in the concrete/asphalt sidewalk to the public way could be a tripping	K 0271	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were identified in the survey findings. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected, however, none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The Ivy Unit Courtyard sidewalk	06/02/2023

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	hazard while exiting from this area in the event of an emergency. Based on interview at the time of observation, the Maintenance Coordinator acknowledged the cracks and level changes along the sidewalk to the public way from this courtyard exit. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b)		was corrected and leveled. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A walk-through was performed by Administrator and Maintenance Coordinator and no further monitoring was deemed necessary due to this being an isolated instance.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 1 courtyard gate was provided with an exit sign. This deficient practice could affect at least 12 residents, as well as staff and visitors. Findings include: Based on observations on 05/04/23 between 11:45 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Coordinator, there was no exit sign on the gate from the courtyard from the lower level north Ivy Unit exit. Based on interview at the time of observation, the Maintenance Coordinator pointed out that there once was an	K 0293	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were identified in the survey findings. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected, however, none were identified. All exit doors have been checked to ensure exit signs are on all the doors. ***The measures or systematic***	06/02/2023

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	exit sign on the gate but had been removed at some time. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1.19(b)		***changes that have been put into place to ensure that the deficient practice does not recur include:*** The Maintenance Coordinator added an exit sign on the gate from the courtyard near the Ivy Unit exit. All exit doors have been checked to ensure exit signs are on all the doors. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that the above corrective actions and changes are being followed. This tool will be completed by the Maintenance Coordinator or designee, weekly for four weeks, then monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	
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 automatic fire extinguishing system in			

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	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 the corridor door to 1 of over 10 hazardous area doors, such as storage room door, was provided with a properly operating self closing device. This deficient practice could affect at least 12 residents, as well as staff and visitors in the Ivy Unit. Findings include: Based on observations on 05/04/23 between 11:45 a.m. and 1:45 p.m. during a tour of the facility with	K 0321	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were identified in the survey findings. ***Other residents that have the potential to be affected have been identified by:*** No residents were identified as being negatively affected by the cited deficient practice.	06/02/2023

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	the Maintenance Coordinator, the Environmental Services Storage Room within the Medical Records Office was over 50 square feet in size and was full of combustible items such as cardboard boxes, totes, plus paper and plastic items. The door to this storage room was provided with a self closing device, however, it would not close the door completely when tested several times. The door frame on the latching side of the door was damaged and would not allow the door to close fully automatically. Furthermore, the corridor door from the Medical Records Office was not provided with a self closing device. Based on interview at the time of observation, the Maintenance Coordinator agreed the damaged door frame to the Environmental Services Storage Room was keeping the door from closing fully automatically. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b)		***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The Maintenance Coordinator adjusted the Environmental Services Storage Room door including moving the striker plate back and refastening the door jam to the wall to ensure the door would self-close. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that the above corrective actions and changes are being followed. This tool will be completed by the Maintenance Coordinator or designee, weekly for four weeks, then monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	
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			

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	accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	1. Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was inspected every five years in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 14.2.1 states an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. Alternative nondestructive examination methods shall be permitted. Non-metallic pipe shall not be required to be inspected internally. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice affects all residents, staff and visitors. Findings include:	K 0353	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were identified in the survey findings. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected, however, none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Maintenance Coordinator notified the company that conducts the pipe inspection that it needed to be completed and it was completed on 5/4/2023. On 5/4/2023, the contracted company was made aware of the loose and	06/02/2023

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	Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, documentation of an internal inspection of the wet sprinkler system performed within the most recent five year period was not available for review. The most recent internal pipe inspection provided was dated 03/12/18. Based on interview at the time of record review on 05/04/23, the Maintenance Coordinator said the five year internal pipe inspection was performed this morning (05/04/23), but there was no documentation with results of the inspection provided by the sprinkler vendor at the time of exit. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 sprinkler system. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff,		painted sprinkler heads and replaced fixtures. The company was notified and replaced the sprinkler cabinet box. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that the above corrective actions and changes are being followed. This tool will be completed by the Maintenance Coordinator or designee, weekly for four weeks, then monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	and visitors in the facility. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Coordinator present, there was no monthly sprinkler system control valves inspection documentation for the past 12 month period. Based on interview at the time of record review, the Maintenance Coordinator confirmed the lack of sprinkler system inspections on the control valves during the past 12 months. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems spare sprinkler cabinets were properly maintained. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility.			

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	Findings include: Based on observations on 5/04/23 between 11:45 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Coordinator, the spare sprinkler cabinet in the sprinkler riser room had four spare sprinkler heads that were laying loosely and not in slots, which could cause breakage to the sprinkler heads if falling out when opening the cabinet door. Based on interview at the time of observation, the Maintenance Coordinator acknowledged there were four spare sprinkler heads in the spare sprinkler cabinet laying loose and not secured in their own slots. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b) 4. Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 5 smoke compartments covered with paint were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect at least 12 resident, as well as staff and visitors while in the Ivy Unit smoke compartment. Findings include:			

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	Based on observations on 05/04/23 between 11:45 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Coordinator, there were two sprinkler heads ceiling area of the Ivy Unit Lobby were covered with black paint. Based on interview at the time of observations, the Maintenance Coordinator agreed the two sprinkler heads in the ceiling area of the Ivy Unit Lobby were covered with black paint and should be replaced. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b)			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 2 of over 10 portable fire extinguishers had documented annual maintenance in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.3.1.1.1 states fire extinguishers shall be subject to maintenance at intervals of not more than one year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 7.3.3 states each fire extinguisher shall have a tag or label securely	K 0355	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were identified in the survey findings. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected. All fire extinguishers have been checked to ensure no others require inspection and maintenance.	06/02/2023

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	attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations on 05/04/23 between 11:45 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Coordinator, the ABC type portable fire extinguishers in the Medical Records Office and the Beauty Shop/Salon had affixed maintenance tag documenting the date the most recent annual maintenance was performed as February of 2021. All other fire extinguishers in the facility had affixed maintenance tags documenting the date the most recent annual maintenance was performed in June of 2022. Based on interview at the time of each observation, the Maintenance Coordinator acknowledged the two aforementioned portable fire extinguishers did not have documented annual maintenance within the most recent twelve month period. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3-1.19(b)		***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The Maintenance Coordinator notified our fire system company and they came out to inspect and maintenance the two fire extinguishers. The Medical Records Office and Beauty Shop fire extinguishers have been added to the inspection documentation. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that the above corrective actions and changes are being followed. This tool will be completed by the Maintenance Coordinator or designee, weekly for four weeks, then monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms,			

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	treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 1 of 4 areas open to the corridor were separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect at least 20 or more residents, as well as staff and visitors. Findings include: Based on observations on 05/04/23 between 11:45 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Coordinator, the main level copier room was open to the corridor without direct supervision from a 24 hour station (i.e., Nurses' Station). Furthermore, LSC 19.3.6.1(7) was not met because the main level copier room was not protected by an electrically supervised automatic smoke detection system. Based on interview at the time of observation, the Maintenance Coordinator agreed this area was not provided with an electrically supervised automatic smoke detector or a door to the egress	K 0361	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were identified in the survey findings. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected, however, none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The Maintenance Coordinator notified our fire system company to install a smoke detector in the copy room. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A audit of all smoke detectors was conducted by Administrator and Maintenance Coordinator. After the audit was completed, showing no further concerns, it was deemed that no further monitoring was necessary.	06/02/2023

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	corridor and was not directly supervised by a 24 hour station (i.e., Nurses' Station). This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference. 3.1-19(b)			
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure 1 of 5 smoke barrier walls was protected to maintain the smoke 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 at least 12 residents, as well as staff and visitors in the lower level Ivy Unit. Findings include: Based on observations on 05/04/23 between 11:45 a.m. and 1:45 p.m. during a tour of the facility with	K 0372	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were identified in the survey findings. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected, however, none were identified. All visible expandable foam was audited to ensure compliance.	06/02/2023

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	the Maintenance Coordinator, the smoke barrier wall above the smoke barrier doors in the Ivy Unit had six penetrations of conduits and water lines through the smoke barrier wall not proper fire stopped. There was expandable spray foam that had been covered with black paint around the conduits and water lines that penetrated the smoke barrier wall above the smoke barrier doors. Based on interview at the time of observation, the Maintenance Coordinator said there was no documentation available to show that the expandable foam used was a proper and approved fire stop material. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b)		***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The Maintenance Coordinator removed all the improper expandable foam and replaced all that was removed with an approved fire rating caulking. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that the above corrective actions and changes are being followed. This tool will be completed by the Maintenance Coordinator or designee, weekly for four weeks, then monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	
K 0511 SS=F Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric			

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	Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure 4 of 4 electrical panels observed in the facility corridors were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on an observations on 05/04/23 between 11:45 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Coordinator, all four electrical panels observed in the facility corridors were unlocked when tested. The panels included breakers to a variety of items in the facility. Based on interview at the time of each observation, the Maintenance Coordinator agreed all electrical panels in the facility corridors need to be locked. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b)	K 0511	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were identified in the survey findings. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected, however, none were identified. All electrical panels were checked to ensure they are locked. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All electrical panels are locked and the Maintenance Coordinator has the key. A GFCI was added to the outlet identified in the staff break room. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that the above corrective actions and changes are being followed. This tool will be completed by the Maintenance Coordinator or designee, weekly for four weeks, then monthly for three months, and then quarterly for three	06/02/2023

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	2. Based on observation and interview, the facility failed to ensure 1 of over 10 wet locations, were provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection.		quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	(5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect mostly staff while in the Staff Break Room. Findings include: Based on observations on 05/04/23 between 11:45 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Coordinator, the electric receptacle within five feet of the sink in the Staff Break Room was not provided with a GFCI receptacle. When tested with a GFCI testing device the receptacle did not break the electrical circuit. Based on interview at the time of observation, the Maintenance Coordinator agreed the receptacle in the Staff Break Room was not properly GFCI protected.			

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	This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b)			
K 0531 SS=F Bldg. 01	NFPA 101 Elevators Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 Based on record review, observation, and interview; the facility failed to maintain testing of 1 of 1 elevators firefighter recall in accordance with 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with fire fighters' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the	K 0531	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were identified in the survey findings. ***Other residents that have the potential to be affected have***	06/02/2023

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	premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, there was no documentation available for the monthly firefighter recall for the elevator for the past twelve months. Based on interview at the time of record review, the Maintenance Coordinator said he does not document a monthly inspection and testing of the firefighter recall for the elevator. Based on observation on 05/04/23 between 11:45 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Coordinator, the elevator was equipped with a firefighter recall key operation at the main floor level. This was confirmed by the Maintenance Coordinator at the time of observation. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b)		***been identified by:*** No residents were identified as being negatively affected by the cited deficient practice. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The Maintenance Coordinator checked the firefighter recall for the elevator and added this check to his monthly elevator checks. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that the above corrective actions and changes are being followed. This tool will be completed by the Maintenance Coordinator or designee, monthly for three months, then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire			

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	conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to ensure 12 of 12 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 05/04/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Coordinator present, all 12 fire drill reports performed during the past 12 month period did not include documentation for the transmission of the alarm to the monitoring company. Based on interview at the time of record review, the Maintenance Coordinator acknowledged there was no information on all 12 fire drill reports to verify that transmission of the alarm was received by the monitoring company. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference. 3-1.19(b)	K 0712	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were identified in the survey findings. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected, however, none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Maintenance Coordinator and Administrator created a quarterly plan for timings of fire drills. Documentation of the fire alarm's signal transmission was received for the fire drills that occurred in the past year. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that the	06/02/2023

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	2. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 05/04/23 between 9:30 a.m. and 11:45 a.m. with the Maintenance Coordinator present, four of four, second shift (evening) fire drills were performed between 3:00 p.m. and 4:05 p.m. Based on interview at the time of record review, the Maintenance Coordinator acknowledged the times the second shift fire drills were performed and agreed the times were not varied enough. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b)		above corrective actions and changes are being followed. This tool will be completed by the Maintenance Coordinator or designee, monthly for three months, then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	
K 0761 SS=C Bldg. 01	Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 2 of 2 stairwell fire door assemblies was completed in accordance with 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	K 0761	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were identified in the survey findings. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected, however, none were identified.	06/02/2023

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	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, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 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.		***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The Maintenance Coordinator inspected the fire doors, then added the stairwell fire doors to the quarterly fire door inspection. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** An audit was performed by the Administrator and the Maintenance Coordinator of all the fire doors on the fire door inspection log and no further monitoring outside of the quarterly fire door inspection was deemed necessary.	

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	(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, as well as staff, and visitors. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, the facility was unable to provide documentation for an annual inspection of the two stairwell fire door assemblies during the past 12 month period. Based on interview at the time of record review, the Maintenance Coordinator said there was no documentation of an annual inspection of the two stairwell fire door assemblies. Based on observations during a tour of the facility with the Maintenance Coordinator on 05/04/23 between 11:45 a.m. and 1:45 p.m., there were two stairwell fire door assemblies noted in the facility. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 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			

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	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, NFPA 111, 700.10 (NFPA 70)			
	1. Based on record review and interview, the facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service 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	K 0918	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were identified in the survey findings. ***Other residents that have the potential to be affected have been identified by:*** No residents were identified as being negatively affected by the cited deficient practice. ***The measures or systematic***	06/02/2023

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	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 (Load Bank Test) 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 occupants in the facility. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, the monthly load percentage for the diesel powered generator was documented less than 30% during the past 12 month period. Based on interview at the time of record review, the Maintenance Coordinator acknowledged the generator ran under load on a monthly basis but does not achieve 30% of the name plate rating. Additionally, the Maintenance Coordinator acknowledged a load bank test for the generator had not occurred within the past 12 months. The most recent diesel generator load bank test was dated 04/08/22. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain a complete written record		***changes that have been put into place to ensure that the deficient practice does not recur include:*** The Maintenance Coordinator contacted generator company and a load bank test was completed on 5/17/2023 and a fuel sample was sent out. The load bank test will have to be completed annually due to the inability to meet the 30% threshold. A timeframe for the cool down period was added to the monthly maintenance check list. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** No further monitoring was deemed necessary, the monthly maintenance checks will ensure compliance. A reminder program is in the process of being integrated to ensure compliance with contracted companies to ensure compliance.	

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BETHEL MANOR	6015 KRATZVILLE RD EVANSVILLE, IN 47710

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	of monthly generator load testing for 1 of 1 generator during the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 110, 6.4.2.1.5.9 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m., and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, there was documentation on the generator monthly load test log for a cool down period after the load test, however, it was with a check mark or "yes" only. A time frame was not included. Based on interview at the time of record review, the facility Maintenance Coordinator said the cool down time for the generator was at least 5 minutes, but agreed the check mark or yes was not adequate. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23.			

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	3.1-19(b) 3. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 diesel powered generators. 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. 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, as well as staff and visitors. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, there was documentation of an annual generator inspection dated 01/09/23, however, there was no documentation of an annual fuel quality test for the diesel generator available for review. Based on interview at the time of record review, the Maintenance Coordinator stated the facility does have a diesel generator but after having spoken with the facility's generator inspection vendor it was determined that a fuel sample has not been taken within the past 12 month period. The most recent fuel sample test was performed on 04/20/22. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23.			

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	3.1-19(b) 4. Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, the facility could only provide documentation of an invoice of the four hour test of the emergency generator conducted on 09/02/22. The information and results of the four hour test were not available for review. This was confirmed by the Maintenance Coordinator at the time of record review. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b)			

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K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure a power strip was not used as a substitute for fixed wiring in 1 of 1 Beauty Shop. 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. This deficient practice could affect one resident and staff.	K 0920	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were identified in the survey findings. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected. All areas that would potentially require the use of a	06/02/2023

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	Findings include: Based on observations on 05/04/23 between 11:45 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Coordinator, there were two curling irons and one hand held hair dryer plugged into a power strip in the Beauty Shop/Salon. Based on interview at the time of observation, the Maintenance Coordinator acknowledged the use of the power strip in the Beauty Shop. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b)		power cord were checked ensure compliance. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The power strip was removed from the beauty shop and education was provided to staff about using power strip. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that the above corrective actions and changes are being followed. This tool will be completed by the Maintenance Coordinator or designee, weekly for three weeks, then monthly for three months, then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).	K 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve	

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	Survey Dates: 05/03/23 and 05/04/23 Facility Number: 000436 Provider Number: 155607 AIM Number: 100275120 At this Life Safety Code survey, the small house health facility at Bethel Manor 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 18, New Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 12 certified beds and had a census of 6 at the time of this survey. The total capacity of both buildings was 75 and had a census of 61 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 05/11/23		the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective June 2, 2023 to the annual licensure survey conducted May 4, 2023. We respectfully request a paper compliance/desk review.	
K 0291 SS=C Bldg. 02	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			

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	Based on record review, observation, and interview; the facility failed to ensure there was complete documentation for the testing of 3 of 3 battery backup lights that were tested monthly for 30 seconds during the past 12 months, and annually for 90 minutes during the past 12 months to ensure the light would provide lighting during periods of power outages. LSC 18.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. 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, as well as staff and visitors in the facility. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Coordinator present, the only emergency light testing documentation available was in the "Cottage Daily Maintenance Log" under "Emergency Light Test". The only thing documented was the date tested each month. The three lights were not identified by number or location or how long they were tested each month. Based on interview at the time of record review, the Maintenance Coordinator said the lights were each tested for 30 seconds each month. Furthermore, there was no documentation of a 90 minute annual test for all three battery light sets available for review. The Maintenance	K 0291	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were identified in the survey findings. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected, however, none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The Maintenance Coordinator added all the emergency lights onto a testing schedule. He also edited his testing schedule to include the time frame. All emergency lights were added to the 30 minute monthly schedule and the 90 minute annual schedule. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** An audit of all emergency light testing was conducted, and no further monitoring was deemed necessary outside the monthly and annual checks.	06/02/2023

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	Coordinator said a 90 minute annual test has not been performed on the three battery lights sets. Based on observations on 05/03/23 between 12:45 p.m. and 1:30 p.m. during a tour of the facility with the Maintenance Coordinator, there were 3 battery powered emergency lights in the facility, two in the garage and one in the fire alarm control panel room. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b)			
K 0324 SS=F Bldg. 02	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: *residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. *cooking facilities open to the corridor in 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			

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	Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, there was no inspection	K 0324	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were identified in the survey findings. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected. The exhaust system was immediately serviced. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The Maintenance Coordinator contacted the company that services the exhaust system to service the exhaust system and ensure the Rehab Cottage is on a semi-annual routine cleaning schedule. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The exhaust hood system was serviced at the Rehab Cottage and placed on a semi-annual cleaning schedule, reports of the cleaning will be kept by the Maintenance Coordinator. No outside monitoring was deemed necessary.	06/02/2023

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	documentation available during the past twelve months for the range hood exhaust system. Based on interview at the time of record review, the Maintenance Coordinator said a contract was not in place for the range hood exhaust system inspection for the Cottage House. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b)			
K 0345 SS=F Bldg. 02	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 1. Based on record review and interview, the facility failed to ensure documentation was available to show that all 23 smoke detectors were sensitivity tested within the past 24 months or prior. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of	K 0345	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were identified in the survey findings. ***Other residents that have the potential to be affected have been identified by:*** No residents were identified as being negatively affected by the cited deficient practice. ***The measures or systematic changes that have been put into***	06/02/2023

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	detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, the facility was unable to produce a smoke detector sensitivity report for all 23 smoke detectors for the past 24 month period or prior. Based on interview at the time of record review, the Maintenance Coordinator confirmed there was no smoke detector sensitivity testing documentation available.		***place to ensure that the deficient practice does not recur include:*** At the Rehab Cottage, smoke detector sensitivity testing is not completed due to the system being an intelligent system and being on 24/7 monitoring. The Maintenance Coordinator contacted the contracted company to perform semi-annual visual inspections. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** No further monitoring was deemed necessary. The necessary reports can be found on the companies portal system when needed. The smoke detector sensitivity testing is constant and communicates with the fire panel to send any error codes if there are issues.	

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	This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all occupants. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and 05/04/23 between 9:30 a.m. and 2:34 p.m. with the Maintenance Coordinator present, there was documentation provided regarding an annual fire alarm system inspection dated 06/09/22 by the facility's fire alarm inspection vendor, however, there was no semi-annual visual inspection documentation provided within six months after the annual inspection by either the vendor or in-house maintenance staff. Based on interview at the time of record review, the Maintenance Coordinator said a semi-annual visual inspection of the fire			

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	alarm system's devices has not been performed since the annual fire alarm inspection on 06/09/22. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b)			
K 0353 SS=F Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 sprinkler system. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be	K 0353	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were identified in the survey findings. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to	06/02/2023

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	utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Coordinator present, there was no monthly sprinkler system control valves inspection documentation for the past 12 month period. Based on interview at the time of record review, the Maintenance Coordinator confirmed the lack of sprinkler system inspections on the control valves during the past 12 months. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems spare sprinkler cabinets were properly maintained. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where		be affected, however, none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Maintenance Coordinator notified the company that conducts the pipe inspection that it needed to be completed and it was completed on 5/4/2023. On 5/4/2023, the contracted company was made aware of the loose and painted sprinkler heads and replaced fixtures. The company was notified and replaced the sprinkler cabinet box. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that the above corrective actions and changes are being followed. This tool will be completed by the Maintenance Coordinator or designee, weekly for four weeks, then monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observations on 5/03/23 between 12:45 p.m. and 1:30 p.m. during a tour of the facility with the Maintenance Coordinator, the spare sprinkler cabinet in the sprinkler riser room had only five spare sprinkler heads, and two of the spare sprinkler heads were laying loosely and not in slots, which could cause breakage to the sprinkler heads if falling out when opening the cabinet door. Based on interview at the time of observation, the Maintenance Coordinator acknowledged that there were only five total spare sprinkler heads in the spare sprinkler cabinet and that two of the sprinkler heads were laying loose and not secured in their own slots. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b)			
K 0712 SS=C Bldg. 02	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established			

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	routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7 Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 05/03/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Coordinator present, four of four, second shift (evening) fire drills were performed between 3:00 p.m. and 4:00 p.m. Based on interview at the time of record review, the Maintenance Coordinator acknowledged the times the second shift fire drills were performed and agreed the times were not varied enough. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b)	K 0712	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were identified in the survey findings. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected, however, none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Maintenance Coordinator and Administrator created a quarterly plan for timings of fire drills. Documentation of the fire alarm's signal transmission was received for the fire drills that occurred in the past year. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that the above corrective actions and changes are being followed. This tool will be completed by the Maintenance Coordinator or designee, monthly for three	06/02/2023

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			months, then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	
K 0918 SS=F Bldg. 02	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records			

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	of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service 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 (Load Bank Test) 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 occupants in the facility. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between	K 0918	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were identified in the survey findings. ***Other residents that have the potential to be affected have been identified by:*** No residents were identified as being negatively affected by the cited deficient practice. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The Maintenance Coordinator contacted generator company and a load bank test was completed on 5/17/2023 and a fuel sample was sent out. The load bank test will have to be completed annually due to the inability to meet the 30% threshold. A timeframe for the cool down period was added to the monthly maintenance check list. ***The corrective action taken to monitor performance to assure compliance through quality***	06/02/2023

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	9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, the monthly load percentage for the diesel powered generator was documented less than 30% during the past 12 month period. Based on interview at the time of record review, the Maintenance Coordinator acknowledged the generator ran under load on a monthly basis but does not achieve 30% of the name plate rating. Additionally, the Maintenance Coordinator acknowledged a load bank test for the generator had not occurred within the past 12 months. The most recent diesel generator load bank test was dated 03/31/22. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 110, 6.4.2.1.5.9 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime		***assurance is:*** No further monitoring was deemed necessary, the monthly maintenance checks will ensure compliance. A reminder program is in the process of being integrated to ensure compliance with contracted companies to ensure compliance.	

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	movers. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m., and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, there was documentation on the generator monthly load test log for a cool down period after the load test, however, it was with a check mark or "yes" only. A time frame was not included. Based on interview at the time of record review, the facility Maintenance Coordinator said the cool down time for the generator was at least 5 minutes, but agreed the check mark or yes was not adequate. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b) 3. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 diesel powered generators. 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. 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, as well as staff and visitors.			

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	Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, there was documentation of an annual generator inspection dated 01/09/23, however, there was no documentation of an annual fuel quality test for the diesel generator available for review. Based on interview at the time of record review, the Maintenance Coordinator stated the facility does have a diesel generator but after having spoken with the facility's generator inspection vendor it was determined that a fuel sample has not been taken within the past 12 month period. The most recent fuel sample test was performed on 03/31/22. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b) 4. Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This			

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	deficient practice could affect all building occupants. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, the facility could only provide documentation of an invoice of the four hour test of the emergency generator conducted on 09/02/22. The information and results of the four hour test were not available for review. This was confirmed by the Maintenance Coordinator at the time of record review. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b)			
K 0920 SS=D Bldg. 02	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 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			

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	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 a power strip was not used as a substitute for fixed wiring in 1 of 1 Beauty Shop. LSC 18.5.1 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. This deficient practice could affect one resident and staff. Findings include: Based on observations on 05/03/23 between 12:45 p.m. and 1:30 p.m. during a tour of the facility with the Maintenance Coordinator, there were two curling irons and one hand held hair dryer plugged into a power strip in the Beauty Shop/Salon. Based on interview at the time of observation, the Maintenance Coordinator acknowledged the use of the power strip in the Beauty Shop. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b)	K 0920	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were identified in the survey findings. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected. All areas that would potentially require the use of a power cord were checked ensure compliance. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The power strip was removed from the beauty shop and education was provided to staff about using power strip. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that the above corrective actions and	06/02/2023

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			changes are being followed. This tool will be completed by the Maintenance Coordinator or designee, weekly for three weeks, then monthly for three months, then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	