STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155596	A. BUILDING -- B. WING	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAKELAND REHAB AND HEALTHCARE CENTER	500 N WILLIAMS ST ANGOLA, IN 46703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/28/22 Facility Number: 000474 Provider Number: 155596 AIM Number: 100290510 At this Emergency Preparedness survey, Lakeland Rehab and Healthcare Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 75 certified beds. At the time of the survey, the census was 64. Quality Review completed on 07/29/22	E 0000		
E 0015 SS=C Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1) Subsistence Needs for Staff and Patients §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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	155596	A. BUILDING -- B. WING	07/28/2022

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	section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting.			

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	(3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and Administrator on 07/28/22 at 11:50 a.m. and at 2:00 p.m., the subsistence needs documentation for the emergency preparedness program was incomplete. Documentation for sewage and waste disposal was not available for review. Based on interview at the time of records review, the Maintenance Director and Administrator stated the sewage and waste disposal policy could not be found. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0015	**E015 Subsistence Needs for Staff & Patients** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **Facility has reviewed and updated its Emergency Preparedness Plan to include documentation related to a sewage and waste disposal plan. Communication of**	08/12/2022

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			updates have been completed with Staff, Residents, and necessary visitors. **4)How the corrective actions will be monitored:** **The Maintenance Director/designee will present the Emergency Preparedness Plan monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance:** **08/12/2022.**	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475,			

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	HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training.			

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	(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training.			

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	(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies			

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	and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility	E 0037	**E037 Emergency Preparedness**	08/12/2022

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	failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Maintenance Director and Administrator on 07/28/22 at 11:50 a.m. and at 2:00 p.m., no documentation of annual EPP training and no documentation to show staff could demonstrate knowledge of the EPP was available for review. Based on an interview at the time of records review, the Maintenance Director and Administrator stated the EPP training was conducted this year but could not find the documentation of the EPP training or demonstration of staff knowledge. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		**Training Plan** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **Facility has reviewed and updated its Emergency Preparedness Plan.** **Communication of updates have been completed with Staff, Residents, and necessary visitors. Additional training will take course as necessary and on a annual basis.** **4)How the corrective actions**	

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			will be monitored: The Maintenance Director/designee will present the Emergency Preparedness Plan monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 08/12/2022.**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/28/22 Facility Number: 000474 Provider Number: 155596 AIM Number: 100290510 At this Life Safety Code survey, Lakeland Rehab and Healthcare Center 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	K 0000		

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	National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The resident rooms on the 300 hall and 400 hall had hard wired smoke detectors. The resident rooms on the 200 hall had battery operated smoke detectors. The facility has a capacity of 75 and had a census of 64 at the time of this survey. All areas where the residents have customary access were sprinklered. The facility had a detached shed providing facility services including maintenance supplies that was not sprinklered. Quality Review completed on 07/29/22			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____			

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	Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure10 of 10 sprinkler heads in the kitchen were not loaded and covered with foreign material in accordance with LSC 9.7.5. 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 staff and up to 25 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 07/28/22 at 12:29 p.m., all the sprinkler heads in the kitchen were loaded with dirt and grease. Based on interview at the time of observation, the Maintenance Director confirmed the sprinkler heads in the kitchen were loaded with dirt and grease The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0353	**E053 Sprinkler System-Maintenance and Testing** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **10 of 10 sprinkler heads noted in the survey were evaluated and cleaned of foreign material.** **4)How the corrective actions**	08/12/2022

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			will be monitored: **The Maintenance Director/designee will audit 10 sprinkler heads per week to ensure they are clean of foreign material and bring the audits monthly to the QAPI Committee meeting for review and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 08/12/2022.**	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the	K 0372	**K372: Subdivision of Building Spaces- Smoke Barrier**	08/12/2022

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	155596	A. BUILDING 01 B. WING	07/28/2022

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LAKELAND REHAB AND HEALTHCARE CENTER	500 N WILLIAMS ST ANGOLA, IN 46703

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	passage of wire and/or conduit through 2 of 5 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 40 residents in three smoke compartments. Findings include: Based on observations with the Maintenance Director on 07/28/22 at 2:00 p.m. and at 2:10 p.m., the following unsealed penetrations were discovered: a) Above the drop ceiling of the 300-hall smoke wall there were 2 unsealed ½ inch gaps around wires. b) Above the drop ceiling of the therapy-hall smoke wall there was an inch unsealed gap around wires at the end of a pipe sleeve. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned smoke walls contained unsealed penetrations. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**Construction** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **Facility has assessed all identified smoke barrier corridor doorways and walls to ensure no penetrations are present. Any penetrations identified in the audit will be corrected. Areas A and B noted in the 2567 have been corrected.** **4)How the corrective actions**	

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			will be monitored: **The Maintenance Director/designee will inspect smoke barrier walls and corridor doors monthly for functionality. Completion of inspection will be presented to the QAPI Committee during QAPI Meetings to ensure compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance:** **08/12/2022**	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9			

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	Based on observation and interview, the facility failed to ensure 1 of 5 sets of smoke barrier doors assemblies would restrict the movement of smoke for at least 20 minutes. This deficient practice could affect 30 residents in two smoke compartments Finding include: Based on observations with the Maintenance Director on 07/28/22 at 1:50 p.m., the smoke barrier door assembly by therapy had two holes measuring 1/2 of an inch that went through the door frame. Based on an interview at the time of observation, the Maintenance Director agreed there were holes through the smoke door frame. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0374	**K374: Subdivision of Building Spaces- Smoke Barrier Doors** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **Facility has assessed all identified smoke barrier corridor doorway assemblies to ensure proper functionality and no penetrations are present.** **Any areas of concern identified in the audit will be corrected. The two holes noted in the 2567 on the smoke**	08/12/2022

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			barrier door assembly have been corrected. **4)How the corrective actions will be monitored:** **The Maintenance Director/designee will inspect smoke barrier walls and corridor doors monthly for functionality. Completion of inspection will be presented to the QAPI Committee. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 08/12/2022.**	
K 0761 SS=E Bldg. 01	Based on observation and interview, the facility failed to maintain annual testing of 1 of 1 rolling fire door in accordance with NFPA 80. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80 5.2.1 requires fire door assemblies shall be inspected and tested not less than annually, and a written record of the	K 0761	**K761 Maintenance, Inspection & Testing-Door** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or***	08/12/2022

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	inspection shall be signed and kept for inspection by the AHJ. This deficient practice could affect 25 residents in the main dining room. Findings include: Based on observation with the Maintenance Director on 07/28/22 at 12:30 p.m., there was a rolling fire door/window between the kitchen and dining room. The tag on the rolling fire door indicated the last annual test was performed in July 2020. Based on interview at the time of observation, the Maintenance Director stated the fire door/window has not been inspected since July of 2020. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		***conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **Annual Testing was scheduled and is to be completed on the rolling fire door/window between the kitchen and dining room. Testing will be completed on an annual basis moving forward.** **4)How the corrective actions will be monitored:** **The Maintenance Director/designee will present the inspection to the QAPI Committee. The report will be reviewed in Quality Assurance Meeting annually to ensure 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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			5) Date of compliance: 08/12/2022.	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and interview, the facility failed to ensure non-hospital grade electrical receptacles at 43 of 43 resident sleeping rooms were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at	K 0914	**K914: Electrical Systems-Maintenance and Testing** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of***	08/12/2022

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	intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 07/28/22 between 12:00 p.m. and 2:00 p.m., the facility's 43 resident sleeping rooms contained four to eight non-hospital-grade electrical receptacles. Based on records review at 11:30 a.m., no documentation was available to show the last time the electrical receptacles in resident sleeping rooms were tested. Based on interview at the time of the observation and records review, the Maintenance Director confirmed all the electrical receptacles in the resident sleeping rooms were not hospital-grade and stated it is unknow the last time the annual testing was completed. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		***this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **Facility has completed annual testing on 43 of the 43 receptacles located in the resident sleeping rooms.** **4)How the corrective actions will be monitored:** **The Maintenance Director/designee will test 10 of the 43 noted receptacles monthly and present findings to the QAPI Committee during QAPI Meetings to ensure compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any**	

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			trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 08/12/2022**	