STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. BUILDING -- B. WING	05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA HOME - A WATERS COMMUNITY	2640 COLD SPRING RD INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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: 05/12/22 Facility Number: 000376 Provider Number: 155717 AIM Number: 100275510 At this Emergency Preparedness survey, Alpha Home - a Waters Community was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 86 certified beds. At the time of the survey, the census was 54. Quality Review completed on 05/16/22 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	**: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
E 0041 SS=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)			

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	(e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system 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			

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	this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (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.			

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	(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). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Generators - Monthly Test Log" documentation for the most recent twelve month period with the Administrator during record review from 9:30 a.m. to 12:05 p.m. on 05/12/22, monthly load testing documentation for the facility's diesel fuel fired emergency generator for the four month period of September 2021 through December 2021 was not available for review. Review of "Emergency Generators - Weekly Inspection Checklist" documentation for the most recent twelve month period indicated weekly emergency generator inspection documentation for the facility's diesel fuel fired emergency generator after 04/12/21 but before 04/18/22 was also not available for review. Based on interview at the time of record review, the Administrator stated she had to fire the former Maintenance Director in December 2021, he may have taken Life Safety Code records with him and agreed monthly and weekly	E 0041	**E041** – It is the intent of the facility to ensure 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) to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a) On May 25, 2022 the Administrator educated the Maintenance Supervisor/designee on the requirement that the Emergency Preparedness Policy Manual must include weekly testing and monthly load testing of the emergency generator to meet set standards. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a) All residents and all staff and visitors have the potential to be affected but none were. The facility has only one Emergency Preparedness Policy Manual. **3. MEASURES TO PREVENT REOCCURRENCE**: A) Maintenance Supervisor/designee will work with	06/03/2022

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	emergency generator testing and inspection documentation for the aforementioned periods within the most recent twelve month period was not available for review. This finding was reviewed with the Administrator during the exit conference.		the Administrator to review the Emergency Preparedness Policy Manual and ensure weekly testing and monthly load testing of the emergency generator is conducted and recorded in the Emergency Preparedness Manual to meet set standards. If any issues are discovered, they will be addressed and resolved immediately. B) The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. **4. MONITORING CORRECTIVE ACTION**: A) The results will be presented by the Maintenance Supervisor/designee to the Administrator at least annually and the Administrator will present the results at the Quality Assurance/Performance Improvement (QA/PI) meeting. Results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 3, 2022.**	

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/12/22 Facility Number: 000376 Provider Number: 155717 AIM Number: 100275510 At this Life Safety Code survey, Alpha Home - a Waters Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with hard wired smoke detection in the corridors, spaces open to the corridors, and in all resident sleeping rooms. The facility has a capacity of 86 and had a census of 54 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except for one detached storage shed. Quality Review completed on 05/16/22	K 0000	**: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	

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K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to maintain latching hardware on 1 of 3 sets of smoke barrier doors per LSC Section 4.6.12.3. LSC Section 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the smoke barrier door set for the 100 Hall. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:30 p.m. to 2:10 p.m. on 05/12/22, the latching mechanism at the top of the west door in the corridor door set at the entrance to the 100 Hall failed to protrude into the latching plate on the door frame when tested to close multiple times. Each door in the door set was equipped with an affixed fire resistance rating (FRR) label stating the door was rated at 90 minutes FRR. Based on interview at the time of the observations, the Administrator agreed the latching hardware for the west door in the smoke barrier door set at the entrance to the 100 Hall failed to latch into the door frame when tested to close multiple times.	K 0100	**K100**– It is the intent of the facility to ensure to maintain latching hardware on smoke barrier doors per LSC Section 4.6.12.3 to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. The Maintenance Supervisor/designee will repair the latching mechanism at the top of the west door in the corridor door set at the entrance to the 100 hall so that it latches fully into the door frame to meet set standards. The Administrator will verify the repair when completed . 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee inspected all smoke barrier doors throughout the facility and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On May 25, 2022 the Administrator educated the Maintenance Supervisor/designee	06/03/2022

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	This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		on the requirement that latching hardware on smoke barrier doors must be maintained in good working condition to meet set standards. b. Maintenance Supervisor/designee will inspect all smoke barrier doors throughout the facility monthly to ensure they are maintained and in good working condition as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction	

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			developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 3, 2022.**	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 6 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility from the 400 Hall. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:30 p.m. to 2:10 p.m. on 05/12/22, a wooden recycling container was stored up against the wall in the corridor outside the Director of Nursing's (DON) Office in the 400 Hall. The container protruded two feet into the six foot width of the corridor. Based on interview at the time of the observations, the	K 0211	**K211** – It is the intent of the facility to ensure to provide means of egress continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On May 12, 2022 the Maintenance Supervisor/designee removed the wooden recycling container from the wall in the corridor outside of Director of Nursing's office in the 400 hall to meet set standards. The Administrator verified the removal on May 12, 2022 . 2. **ALL OTHERS WITH**	06/03/2022

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	Administrator stated the container is normally stored in the hallway and agreed the 400 Hall was not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		**POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On May 12, 2022 the Maintenance Supervisor/designee inspected all corridor means of egress and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On May 24th and 25th the Administrator educated the Maintenance Supervisor/designee and other staff on the requirement that the Corridors to meet set standards. b. Maintenance Supervisor/designee will inspect all corridor means of egress throughout the facility weekly for obstructions as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance	

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			Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 3 , 2022.**	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1,			

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	19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected			

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	throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 3 of 7 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:30 p.m. to 2:10 p.m. on 05/12/22, the main entrance, the exit door in the short hallway by the entrance door set to the 100 Hall and the exit door in the 300 Hall were each marked as a facility exit with an exit sign and each exit door was not equipped with a delayed egress lock. Each exit door could be opened by entering a four digit code into a keypad at the exit door but the code was not posted. Based on interview at the time of the observations, the Administrator stated only the 200 Hall needs to be a secure wing for Alzheimer's residents and agreed the code was not posted at the aforementioned three exit doors. This finding was reviewed with the Administrator during the exit conference.	K 0222	**K222**– It is the intent of the facility to ensure means of egress through exits are readily accessible for residents without a clinical diagnosis requiring specialized security measures to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. The Maintenance Supervisor/designee will post information to obtain the codes needed to release the exit door in the short hallway by the entrance door set to the 100 hall and the exit door in the 300 hall to meet set standards. The Administrator will verify the posting of the codes. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee will inspect all doors to the means of egress to ensure they were readily available for use and information posted to obtain codes and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On May 25, 2022 the Administrator educated the	06/03/2022

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	3.1-19(b)		Maintenance Supervisor/designee on the requirement that doors must have information posted on how to obtain codes near the doors to meet set standards. b. Maintenance Supervisor/designee will inspect all means of egress throughout the facility weekly to ensure codes remain posted for all doors which require codes for use as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction	

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			developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 3, 2022.**	
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ Based on observation and interview, the facility failed to ensure 1 of 4 smoke compartments were provided with a complete interior finish with a flame spread rating of Class A or Class B for a sprinklered facility. LSC 10.2.3.4 states products required to be tested in accordance with ASTM E 84, Standard Test Method for Surface Burning Characteristics of Building Materials or ANSI/UL 723, Standard for Test for Surface Burning Characteristics of Building Materials shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on	K 0331	**K331** – It is the intent of the facility to ensure smoke compartments are provided with a complete interior finish with a flame spread rating of Class A or Class B for a sprinklered facility to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. Fire-resistant material has been ordered and the maintenance man will apply to the laminate on the corridor walls under the handrails to the floor in the 200 hall and documented on the flame spread logs to meet set	06/03/2022

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	the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. LSC Table A.10.2 permits the following test methods for textile wall coverings: ASTM E 84, Standard Test Method for Surface Burning Characteristics of Building Materials; ANSI/UL 723, Standard for Test for Surface Burning Characteristics of Building Materials; NFPA 286 NFPA 265, Method B This deficient practice could affect over 10 residents, staff and visitors in the 200 Hall. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:30 p.m. to 2:10 p.m. on 05/12/22, a brown colored laminate was affixed to the corridor walls under the handrails to the floor in the 200 Hall. The laminate appeared to be the same material as the flooring installed in the 100 Hall. Based on interview at the time of the observations, the Administrator stated the laminate had not been treated with flame retardant material and agreed flame spread rating documentation for the laminate affixed to the wall in the 200 Hall was not available for review		standards. The Administrator/designee verify when this is complete. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On May 25, 2022 the Administrator/designee educated the Maintenance Supervisor/designee on the requirement that smoke compartment interior finishes throughout the facility must have a flame spread rating of Class A or Class B and documented in the flame spread logs to meet set standards. b. Maintenance Supervisor/designee will inspect all interior finishes in the smoke compartments throughout the facility to ensure they have a flame spread rating of Class A or B as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance	

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	at the time of the survey. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 3, 2022.**	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific			

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	areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 ceiling smoke barriers in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:30 p.m. to 2:10 p.m. on 05/12/22, the following ceiling mounted sprinkler locations were missing its escutcheon: a. 100 Hall Cart Storage room. b. 100 Hall Janitor's closet. c. 100 Hall oxygen storage and transfilling room. d. closet in Room 109. e. closet in Room 206. f. both sprinklers in the Housekeeping Supply room across from the Activities Room. Based on interview at the time of the observations, the Administrator agreed each of the aforementioned ceiling mounted sprinkler	K 0351	**K351**– It is the intent of the facility to ensure to maintain the ceiling construction in ceiling smoke barriers in accordance with NFPA 13 to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. The Maintenance Supervisor/designee will install the escutcheon rings at the following ceiling mounted sprinkler locations: a) 100 hall cart storage room b) 100 hall janitors closet c) 100 hall oxygen storage and transfilling room d) closet in room 109 e) closet in room 206 f) both sprinklers in the housekeeping supply room across from the activities room to meet set standards. The Administrator verify when work completed . **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On May 25, 2022the	06/03/2022

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	locations was missing its escutcheon. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		Administrator educated the Maintenance Supervisor/designee on the requirement that ceiling mounted sprinklers must have an escutcheon ring to meet set standards. b. Maintenance Supervisor/designee will inspect all sprinklers monthly to ensure escutcheon rings are present as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as	

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			deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 3, 2022.**	
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 _____ 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 maintain the ceiling construction in 1 of over 10 storage rooms. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and	K 0353	**K353** – It is the intent of the facility to maintain the ceiling construction of storage rooms to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.The Maintenance Supervisor/designee will install the three suspended ceiling tiles	06/03/2022

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	the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect over 10 residents, staff, and visitors in the vicinity of the storage room by the entrance door to the Alzheimer's wing in the 200 Hall. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:30 p.m. to 2:10 p.m. on 05/12/22, three suspended ceiling tiles were missing in the ceiling in the storage room by the entrance door to the Alzheimer's wing in the 200 Hall. HVAC room by the Workroom by the main lobby. The room was equipped with one pendant sprinkler installed on the suspended ceiling. Based on interview at the time of the observations, the Administrator agreed there were missing ceiling tiles in the aforementioned room. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		missing in the ceiling in the storage room by the entrance door to the Alzheimer's wing in the 200 hall to meet set standards. The Administrator will verify when work is completed. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On May 25, 2022the Administrator educated the Maintenance Supervisor/designee on the requirement that the ceiling must be maintained to meet set standards. 2.Maintenance Supervisor/designee will ensure the ceiling is checked monthly as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will	

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			be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 3, 2022.**	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor			

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	covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 6 of over 40 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 10 residents, staff and visitors in the vicinity or Room 204. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:30 p.m. to 2:10 p.m. on 05/12/22, the following was noted: a. the east door in the kitchen door set from the main dining room was propped in the fully open	K 0363	**K363** – It is the intent of the facility to ensure corridor doors have no impediments to closing and latching into the door frame and would resist the passage of smoke to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On May 12, 2022 the Maintenance Supervisor/designee a) removed the portable meal tray cart from the kitchen door set in the main dining room b) repaired the latching mechanism in the east door so that the door latches fully into the frame. Maintenance	06/03/2022

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	position with a portable meal tray cart. The east door was equipped with a latching mechanism to latch the door into the door frame but the door failed to latch into the door frame when tested to close multiple times. In addition, a one inch in diameter hole was noted below the door handle in the west door in the door set which would not resist the passage of smoke. The main dining room was open to the corridor. b. one of two screws for the latching plate on the door frame for the corridor door to Room 204 was missing which caused the latching plate to be loose and did not allow the corridor door to latch into the door frame. c. the corridor door for Room 306 failed to latch into the door frame when tested to close multiple times. d. a towel was stuffed into the latching mechanism hole in the latching plate on the door frame for the corridor door to Room 310 which prevented the door from latching into the door frame when tested to close. e. a latching plate was screwed into and on top of the latching plate on the door frame for the corridor door to the Clean Utility room by the laundry room which prevented the door from fully closing and latching into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Administrator agreed the aforementioned corridor doors had an impediment to closing and latching into the door frame or would not resist the passage of smoke. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		Supervisor/designee will repair the hole with a 1 hour fire rated material below the door handle in the west door in the door set to meet set standards. . b. On May 13, 2022 the Maintenance Supervisor/designee secured the latching plate on the door frame for the corridor door to room 204 to meet set standards. The Administrator verified the work on May 13, 2022 . c. On May 13, 2022 the Maintenance Supervisor/designee repaired the latching mechanism on the corridor door to room 306 so the door latches fully into the frame to meet set standards. The Administrator verified the work on May 13, 2022 . d. On May 12 the Maintenance Supervisor/designee removed the towel that was stuffed into the latching mechanism hole in the latching plate on the door frame for the corridor door to room 310 to meet set standards. The Administrator verified the work on May 12, 2022 . e. On May 13, 2022 the Maintenance Supervisor/designee repaired the latching plate on the door frame for the corridor door to the clean utility room by the laundry room so the door self closes and fully latches into the frame to meet set standards. The Administrator verified the work on May 13, 2022 .	

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			2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED: a. All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee inspected all corridor doors for impediments, failing latching mechanisms, and gaps and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On May 25, 2022 the Administrator educated the Maintenance Supervisor/designee and staff on the requirement that corridor doors may not have impediments to closing, the latching mechanism latches into the frame, and the doors are free of gaps to resist the passage of smoke to meet set standards. b. Maintenance Supervisor/designee will inspect all corridor doors throughout the facility monthly to ensure the latching mechanisms work properly, impediments to closing are not in place, and the doors have no gaps which would allow the passage of smoke as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. BUILDING 01 B. WING	05/12/2022

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			c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is May 27, 2022.**	

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K 0372 SS=D 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 openings through 1 of 1 ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect over three staff and visitors in the kitchen. Findings include: Based on observations with the Administrator	K 0372	**K372** – It is the intent of the facility to ensure openings through ceiling smoke barriers are protected to maintain the fire resistance rating of the smoke barrier to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. The Maintenance Supervisor/designee will repair the hole in the ceiling of the restroom in the kitchen next to the escutcheon for the sprinkler in the room with a one hour fire rated material to meet set standards. The Administrator will verify when the repair is completed . 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On May 25, 2022 the Maintenance	06/03/2022

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	and the Maintenance Director during a tour of the facility from 12:30 p.m. to 2:10 p.m. on 05/12/22, a one inch hole was noted in the ceiling of the restroom in the kitchen next to the escutcheon for the sprinkler in the room. One layer of 5/8ths inch thick drywall was noted as the ceiling construction for the room. Based on interview at the time of the observations, the Administrator agreed there was a hole in the kitchen restroom ceiling next to the sprinkler for the room. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		Supervisor/designee inspected all smoke barrier walls & ceilings throughout the facility for penetrations and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On May 25, 2022 the Administrator educated the Maintenance Supervisor/designee on the requirement that smoke barrier walls & ceilings must be free of penetrations and voids to meet set standards. b. Maintenance Supervisor/designee will inspect all smoke barrier walls & ceilings throughout the facility monthly for penetrations and voids as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the	

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			Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 3, 2022.**	
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 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 Based on record review and interview, the facility failed to document quarterly fire drills on the: a. first shift for 2 of 4 calendar quarters. b. second shift for 3 of 4 quarters. c. third shift for 2 of 4 quarters. LSC Section 19.7.1.6 requires drills to be	K 0712	**K712** – It is the intent of the facility to ensure to conduct quarterly fire drills on each shift under varied conditions to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**:	06/03/2022

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	conducted quarterly on each shift under varied conditions. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Fire Drill Report" documentation with the Administrator during record review from 9:30 a.m. to 12:05 p.m. on 05/12/22, documentation of a first shift fire drill or staff training documentation on fire drill procedures on the first shift in the fourth quarter (October, November, December) 2021 and in the first quarter (January, February, March) 2022 was not available for review. Documentation of a second shift fire drill or staff training documentation on fire drill procedures on the second shift in the second quarter (April, May, June) 2021, in the third quarter (July, August, September) 2021 and in the fourth quarter 2021 was also not available for review. In addition, documentation of a third shift fire drill or staff training documentation on fire drill procedures on the third shift during the second quarter 2021 and the third quarter 2021 was also not available for review. Based on interview at the time of record review, the Administrator stated the facility operates three shifts per day and agreed documentation of fire drills or staff training on fire drill procedures for the aforementioned shifts and calendar quarters within the most recent twelve month period was not available for review. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		a. On May 25, 2022 the Administrator educated the Maintenance Supervisor/designee on the requirement that fire drills must be conducted at unexpected times under varying conditions at least quarterly on each shift and documented to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. Maintenance Supervisor/designee will ensure fire drills are conducted at unexpected times under varying conditions at least quarterly on each shift and documented on the Fire Drill Report and that documentation be retained in the facility's Life Safety Binder as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. b. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.	

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			4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 3, 2022.**	
K 0911 SS=F Bldg. 01	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) 1. Based on observation and interview, the facility failed to identify protected branch circuits for 1 of 1 electrical panels at the emergency generator transfer switch location in	K 0911	**K911 -** It is the intent of the facility to ensure to identify protected branch circuits for electrical panels at the emergency	06/03/2022

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	accordance with NFPA 70. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 210.5(A) states the grounded conductor of a branch circuit shall be identified in accordance with Article 200.6. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:30 p.m. to 2:10 p.m. on 05/12/22, overcurrent devices in the electrical panel identified as "NDPE1" at the automatic transfer switch location in the 100 Hall Electrical Room did not identify circuits protected by the overcurrent devices. Based on interview at the time of the observations, the Administrator agreed overcurrent devices for the panel did not identify the circuits protected by the device. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure access and working space was maintained in enclosures housing electrical apparatus in 1 of 1 electrical rooms in the 100 Hall. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states working space for equipment operating at 600 volts,		generator transfer switch location are in accordance with NFPA 70 and to ensure access and working space is maintained in enclosures housing electrical apparatus in electrical rooms to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. The Maintenance Supervisor/designee will identify the circuits in the electrical panel identified as NDPE1 at the automatic transfer switch location in the 100 hall electrical room to meet set standards. b. On May 27, 2022 the Maintenance Supervisor/designee removed the one mattress and several boxes that were stored on the floor up against the wall mounted electrical panel identified as I-T-E Switchboard in the 100 hall electrical room to meet set standards. 2. **ALL OTHERS WITH POTENTAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On May 24 and May 25 the Administrator educated the Maintenance Supervisor/designee and staff on the requirement that electrical panels must be identified and access to electrical boxes must be maintained to meet set standards.	

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	nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2) and (3). Distances shall be measured from the live parts if such parts are exposed or from the enclosure front or opening if such are enclosed. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:30 p.m. to 2:10 p.m. on 05/12/22, one mattress and several boxes were stored on the floor up against the wall mounted electrical panel identified as "I-T-E Switchboard" in the 100 Hall electrical room. Based on interview at the time of the observations, the Administrator Director agreed access and working space was not maintained in front of the wall mounted electrical panel at the aforementioned location. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		b. Maintenance Supervisor/designee will inspect all electrical panels throughout the facility monthly to ensure they are identified properly and there are no impediments to accessing the panels as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction**	

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			constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 3, 2022.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the			

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	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, observation and interview; the facility failed to document emergency generator monthly load testing for 4 months of the most recent 12 month period 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 at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generators - Monthly Test Log" documentation for the most recent twelve month period with the Administrator during record review from 9:30	K 0918	**K918** – It is the intent of the facility to ensure to document emergency generator monthly load testing for the most recent 12 month period to meet the requirements of NFPA 110, 2010 edition, the standard for emergency and standby powers systems, chapter 8.4.2 and to ensure a written record of weekly inspections for the emergency generator is maintained of the most recent 52 week period to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN** a. On May 25, 2022the Administrator educated the Maintenance Supervisor/designee on the requirement that monthly load testing of the emergency generator must be completed and documentation retained in the Emergency Preparedness Binder to meet set standards. b. On May 25, 2022 the Administrator educated the Maintenance Supervisor/designee on the requirement that weekly testing of the emergency generator must be completed and documentation retained in the Emergency Preparedness Binder to meet set standards. c. The facility uses LP gas as its fuel source for the generator,	06/03/2022

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	a.m. to 12:05 p.m. on 05/12/22, monthly load testing documentation for the facility's diesel fuel fired emergency generator for the four month period of September 2021 through December 2021 was not available for review. Based on interview at the time of record review, the Administrator stated she had to fire the former Maintenance Director in December 2021, he may have taken Life Safety Code records with him and agreed monthly load testing documentation for the aforementioned four month period in 2021 was not available for review. Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:30 p.m. to 2:10 p.m. on 05/12/22, the facility has one diesel fired emergency generator located outside of the building on the south side of the property. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b) 2. Based on observation, record review and interview; the facility failed to ensure a written record of weekly inspections for the emergency generator set was maintained for 49 weeks of the most recent 52 week period. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generators - Weekly Inspection Checklist" documentation for the most recent twelve month period with the Administrator during record review from 9:30 a.m. to 12:05 p.m. on 05/12/22, weekly emergency generator inspection documentation		not diesel. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. The facility has only one emergency generator. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. Maintenance Supervisor/designee will inspect and test the emergency generator weekly testing and monthly load testing as required and retain documentation of those tests and inspections in the facility's Emergency Preparedness Binder as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. b. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the	

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	for the facility's diesel fuel fired emergency generator after 04/12/21 but before 04/18/22 was not available for review. Based on interview at the time of record review, the Administrator stated she had to fire the former Maintenance Director in December 2021, he may have taken Life Safety Code records with him and agreed weekly emergency generator inspection documentation prior to 04/18/22 for the facility's diesel fuel fired emergency generator was not available for review. Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:30 p.m. to 2:10 p.m. on 05/12/22, the facility has one diesel fired emergency generator located outside of the building on the south side of the property. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 3, 2022.**	