STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155258	A. BUILDING -- B. WING	01/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY	205 MARINE DR ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/02/24 Facility Number: 000160 Provider Number: 155258 AIM Number: 100267190 At this Emergency Preparedness survey, Countryside Manor Health and Living 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 109 certified beds. At the time of the survey, the census was 71. Quality Review completed on 01/04/24	E 0000	January 18, 2024 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: VCVM21 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on January 2, 2024. This letter is to inform you that the plan of correction attached is to serve as Countryside Health & Living Community's credible allegation of compliance. We allege substantial compliance. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 765-649-4558 Sincerely, Keeshan Patel, HFA Administrator	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keeshan Patel	Executive Director	01/18/2024

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

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			Countryside Health and Living Submission of this plan of correction in no way constitutes an admission by Countryside Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
E 0022 SS=C Bldg. --	403.748(b)(4), 416.54(b)(3), 418.113(b)(6)(i), 441.184(b)(4), 482.15(b)(4), 483.475(b)(4), 483.73(b)(4), 485.625(b)(4), 485.68(b)(2), 485.727(b)(2), 485.920(b)(3), 491.12(b)(2), 494.62(b)(3) Policies/Procedures for Sheltering in Place §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [facilities]			

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	155258	A. BUILDING -- B. WING	01/02/2024

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	must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a means to shelter in place for residents, staff, and volunteers who remain in the LTC facility in accordance with 42 CFR 483.73(b)(4). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 01/02/24 at 11:40 a.m., a complete policy and procedure that included a means to shelter in place for residents, staff, and volunteers who remain in the LTC facility was not available	E 0022	**E022** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The Community failed to ensure that the facility had a sufficient shelter-in-place policy. The Emergency Preparedness plan has a policy, and the administrator was not able to give to the surveyor for review. See attached	01/15/2024

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	for review. The were elements of sheltering in place in other policies but not a complete policy describing sheltering in place procedures. Based on interview at the time of record review, the Maintenance Director stated a complete shelter in place policy and procedure was not available to review. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		Shelter in Place policy. Shelter in place is also addressed in other current policies such as Fire Emergencies, Snow Emergencies, Temperature Emergency Procedures, etc. **II. The facility will identify other residents who may potentially be affected by the deficient practice.** All residents and staff could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Administrator and Maintenance Supervisor have been reeducated on where the Shelter in Place Policy and Procedure is kept. . **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit the Emergency Preparedness Plan during their annual CQR. **V. Plan of Correction completion date.**	

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			Plan of Completion date is January 15,2024.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care			

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	Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.			

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	(iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 01/02/24 at 10:02 a.m., the generator lacked required Load Bank test required by LSC and NFPA 110. Based on interview at the time of record review, the Maintenance Director stated the generator was missing some of the required testing. The findings were reviewed with the	E 0041	**K 041** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The community failed to ensure that their generator maintenance paperwork was complete and showed the proper load bank testing. Cummins Crosspoint is the generator company assigned for maintenance and testing of the generator. Load bank testing occurred on 8/09/2023. See the attached documentation showing	01/15/2024

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	Administrator and Maintenance Director at the exit conference.		the Cummins Contract and both the load bank tests. **II. The facility will identify other residents who may potentially be affected by the deficient practice.** All residents and staff could have been affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a TELS task to complete a load bank test annually. See attached Load Bank TELS Task. The Maintenance Supervisor will ensure load bank tests are completed annually and the proper paperwork is available for review during life safety audits. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit the Life Safety Binder during their annual CQR to ensure the proper generator paperwork is there for review. **V. Plan of Correction**	

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/02/24 Facility Number: 000160 Provider Number: 155258 AIM Number: 100267190 At this Life Safety Code survey, Countryside Manor Health and Living Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and fully sprinkled with exception of three electrical closets. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 109 and had a census of 71 at the time of this visit. All areas where residents have customary access were sprinklered except for a garage and a shed	K 0000	**completion date.** Plan of Completion date is January 15th, 2024. January 18, 2024 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: VCVM21 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on January 2, 2024. This letter is to inform you that the plan of correction attached is to serve as Countryside Health & Living Community's credible allegation of compliance. We allege substantial compliance. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 765-649-4558	

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	which houses the generator and were not sprinklered. Quality Review completed on 01/04/24		Sincerely, Keeshan Patel, HFA Administrator Countryside Health and Living Submission of this plan of correction in no way constitutes an admission by Countryside Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
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:			

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	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, 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.			

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	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 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 1 of 6 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect 30 residents in the 300-hall.	K 0222	**K 222** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The community failed to ensure that the exit door located at the end of the 300 operated correctly. The door system in question had a 15 second delayed egress sign on it and also had the code posted at the door. The maglocks are not designed for delayed egress. The Maintenance Superviser removed inaccurate signage on the door. The door was also tested to ensure it unlocked on the activation of the fire alarm system. See attached pictures showing the signage removed and the code	01/15/2024

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	Findings include: Based on observation with the Maintenance Director on 01/02/24 at 12:14 p.m., the 300-hall exit door had a posted 15 second delayed egress sign. When the door was tested, the irreversible process to release the lock was not initiated. Based on interview at the time of observation, the Maintenance Director agreed the door had a posted 15 second delayed egress sign, the delayed egress did not activate, and stated he was unsure if the door was equipped with a 15 second delayed egress. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		posted. **II. The facility will identify other residents who may potentially be affected by the deficient practice.** All residents and staff could be affected by the deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance supervisor was re-educated on the correct means of egress and where and when codes need to be posted. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect all egress doors during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is January 15th, 2024.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities			

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	Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure staff had access to the shutoff switch for 1 of 1 cook tops in the therapy gym. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the following is provided:	K 0324	**K 324** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The community failed to ensure that an oven in the activities room remains off when not in use. The oven has an existing keyed switch on the wall that can turn the oven on and off. The key was not available for the surveyor to see in use as it was in the maintenance office. The community and activities staff have been educated	01/15/2024

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	155258	A. BUILDING 01 B. WING	01/02/2024

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	(a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect five residents in the therapy gym. Findings include: Based on observation with the Maintenance Director on 01/02/24 at 12:14 p.m., the cooktop in therapy was not in use and was still connected to power. There was a key switch on the wall to deactivate the cooktop from power, but no one had the key for the switch. Based on interview at the time of observation, the Maintenance Director agreed the cooktop was not disconnected from power and stated there was not a key for the deactivation switch. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		that the oven shall remain off while not being supervised. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and staff that use the activity space could have been affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The maintenance director will maintain the safety key, and the oven will only be turned on during time dictated by the activities schedule. **IV The facility will monitor the corrective action by implementing the following measures.** The maintenance director will complete weekly audits to ensure that activities oven remains off when not in use. A weekly TELS task has been added to ensure it is not in use while unoccupied. See TELS task. **V. Plan of Correction completion date.**	

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			Plan of Completion date is January 15th, 2024 .	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure 3 of 3 electrical closets were provided with adequate coverage to ensure the facility was protected throughout by an approved automatic sprinkler system in accordance with NFPA 13. This deficient practice could up to 40 residents in three smoke compartments. Findings include: Based on observation with the Maintenance	K 0351	**K 351** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The community failed to ensure that three utility closets were covered by sprinklers. The	01/15/2024

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	Director on 01/02/24 between 12:14 p.m. and 1:15 p.m., there were three cubbies/closets built around electrical panels in the kitchen, therapy storage, and the records office. The inside space measured 3 feet by 6 feet and was not covered by the sprinkler system. Based on interview at the time of observation, the Maintenance Director agreed the space inside the cubbies/closets were not covered by the sprinkler system. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		Maintenance Supervisor has removed the doors to the closets to ensure the proper fire protection. **II. The facility will identify other residents who may potentially be affected by the deficient practice.** All staff and residents could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** This is a permanent solution to the problem and no further follow up is needed. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect all closets and areas during their annual CQR to ensure the proper fire protection. **V. Plan of Correction completion date.** Plan of Completion date is January 15th, 2024	

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K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 electrical outlets behind the dryer in laundry and 1 of 1 electrical outlets by the bed in room 305 were protected according to LSC 19.5.1. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect 1 resident and most staff in the service hall. Findings include: Based on observation with the Maintenance Director on 01/02/24 at 12:34 p.m. and 12:45 p.m., the outlets behind the dryers in laundry and by bed 305 did not contain a faceplate. Based on interview at the time of observation, the Maintenance Director agreed the outlets were not covered with a faceplate. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)	K 0511	**K 511** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The community failed to ensure that two outlet faceplates were not installed. The Maintenance Supervisor install faceplates on the outlet behind the dryers and in resident room 305. See attached picture of them installed. **II. The facility will identify other residents who may potentially be affected by the deficient practice.** All staff and one resident could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**	01/12/2024

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			The Maintenance Supervisor has been re educated on the need to have outlets covers on all plugs and switches within the community. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect all outlets during their annual outlet inspection to ensure all faceplates are on. **V. Plan of Correction completion date.** Plan of Completion date is January 12, 2024.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances,			

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	secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation, records review, and interview, the facility failed enforce 1 of 1 non-smoking policies and ensure cigarette butt were disposed in a non-combustible container with a self-closing lid. This deficient practice could affect staff around the employee entrance and 12 residents using the 300-hall exit. Findings include: Based on observations with the Maintenance Director on 01/02/24 between 9:30 a.m. and 1:10 p.m., smoking on property was evident due to the following: a.) Upon arrival to the facility two staff members were smoking in the garage by the employee entrance. b) There were over 50 cigarette butts on the ground outside the employee entrance. c) The trashcan by the employee entrance was mixed with cigarette butts and trash. d) A plastic bucket by the garage contained over 100 cigarette butts e) There were over 20 cigarette butts on the ground around the generator.	K 0741	**K 741** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The community failed to enforce the non-smoking policy and ensure cigarette butts were disposed of appropriately. All staff have been in serviced on the campus nonsmoking policy. See attached policy and sign off sheet. **II. The facility will identify other residents who may potentially be affected by the deficient practice.** All staff and residents could be affected by this deficient practice.	01/17/2024

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	f) There were 10 cigarette butts on the ground outside the 300-hall exit. Based on records review at 1:20 p.m., the smoking policy stated the facility may choose to allow or not allow smoking on campus. This facility chose to be a non-smoke facility and had "no smoking" placards on the exterior of the building. Based on interview at the time of observation and records review, the Maintenance Director stated the facility is a non-smoking campus and confirmed there was smoking on property due to cigarette butts on the ground. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor or the designee will round weekly to ensure that cigarette butts are not present on the property and the policy is being enforced. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect all outside areas during their annual CQR to ensure the non smoking policy is being enforced. **V. Plan of Correction completion date.** Plan of Completion date is January 17th, 2024 .	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance			

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	and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to exercise 1 of 1 generators annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency	K 0918	**K 918** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The community failed to ensure that their generator maintenance paperwork was complete and showed the proper load bank testing. Cummins Crosspoint is	01/15/2024

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	Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 01/02/24 at 10:47 a.m., the monthly diesel-powered generator load testes showed the last 12 load percentage were between 11% and 13%. Therefore, the generator is required to perform an annual load bank test, but there was no documentation of a load bank test for the past 12 months. Based on interview at the time of record review, the Maintenance Director stated the generator dose not achieve 30 % load of the generator's name plate rating and a load bank test for the generator has not occurred within the past year. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		the generator company assigned for maintenance and testing of the generator. Load bank testing occurred on 8/09/2023. See attached documentation showing the Cummins Contract and both the load bank tests. **II. The facility will identify other residents who may potentially be affected by the deficient practice.** All residents and staff could have been affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a TELS task to complete a load bank test annually. See attached Load Bank TELS Task. The Maintenance Supervisor will ensure load bank tests are completed annually and the proper paperwork is available for review during life safety audits. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit the Life Safety Binder during their annual CQR to ensure the	

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			proper generator paperwork is there for review. **V. Plan of Correction completion date.** Plan of Completion date is January 15th, 2024.	