STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155699	A. BUILDING -- B. WING	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF HARTFORD CITY	715 N MILL ST HARTFORD CITY, IN 47348

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/05/24 Facility Number: 000290 Provider Number: 155699 AIM Number: 100379970 At this Emergency Preparedness survey, Envive of Hartford City was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 78 and had a census of 29 at the time of this survey. Quality Review completed on 12/10/24	E 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Survey conducted December 5, 2024.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/05/24 Facility Number: 000290 Provider Number: 155699 AIM Number: 100379970 At this Life Safety Code survey, Envive of Hartford City was found not in compliance with Requirements for Participation in	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Survey conducted December 5, 2024.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sarah Jackman	HFA	12/21/2024

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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	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 was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and has smoke detectors hard wired to the fire alarm system in resident sleeping rooms in the 200 Hall. The facility has battery operated smoke detectors in resident sleeping rooms in the 100 Hall. The facility has a capacity of 78 and had a census of 29 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 12/10/24			
K 0227 SS=E Bldg. 01	NFPA 101 Ramps and Other Exits Based on observation and interview, the facility failed to ensure ramps in 2 of 6 exit discharges were in accordance with the provisions of LSC 7.2.5. Table LSC 7.2.5.2 (b) states the maximum slope for existing ramps shall be 1 in 8. Landings shall be in accordance with Section 7.2.5.3.2. Handrails complying with LSC 7.2.2.4 shall be provided along both sides of a ramp run with a rise greater than 6 inches, unless otherwise provided in LSC 7.2.5.4.4. This deficient practice could affect over 15 residents, staff and visitors if needing to use the facility exits by Room 102 and by Room 121.	K 0227	**K227 Ramps and other Exits** **1 What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?** *A contractor will be obtained to fix or replace ramps to meet CMS requirements.*	11/01/2025

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	Findings include: Based on observations with the Administrator, the Director of Nursing, the Director of Maintenance and the Field Maintenance Supervisor during a tour of the facility from 1:20 p.m. to 3:20 p.m. on 12/05/24, the following was noted: a. the ramp in the exit discharge outside the facility exit door by Room 102 measured 25.5 feet in length with a rise of seven inches over each two feet in the length of the ramp. The ramp was not provided with handrails. b. the ramp in the exit discharge outside the facility exit door by Room 121 measured 6.6 feet in length with a rise of nine inches over the length of the ramp. The ramp was not provided with handrails. Based on interview at the time of the observations, the Director of Maintenance and the Field Maintenance Supervisor confirmed the measurements and agreed each of the aforementioned two exit discharge ramps were not provided with handrails. These findings were reviewed with the Administrator, the Director of Nursing, the Director of Maintenance and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		. **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** *This deficient practice could affect up to 15 residents,* *A contractor will be obtained to fix or replace ramps to meet CMS requirements.* **3. What measures will be putting place or what systemic changes will be made to ensure that the deficient practice does not occur?** *The Director of Maintenance was educated by the Executive Director on*K227 Ramps and other Exits**.** Once repaired a quarterly inspection will be added to the Tels system **4. How the corrective action will be monitored to ensure the**	

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			deficient practice will not recur i.e., what quality assurance program will be put into place? *This TeIs task will be reviewed by the Safety/QAPI committee Lead by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement Until 100% compliance is achieved.* **5. Date of Completion:** *11-1-25* *Waiver submitted*	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to ensure all fire alarm system initiating devices were tested in accordance with the schedules for testing frequency in NFPA 72. LSC Section 19.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6. LSC Section 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electric Code and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, Section 14.4.5 states testing shall be performed in accordance with the schedules in Table 14.4.5. Table 14.4.5 at 15(e) states the requirements of 14.4.5.5 shall apply to heat detectors. Section 14.4.5.5 states restorable fixed-temperature, spot-type heat detectors shall be tested in accordance with	K 0345	**K345 Fire Alarm - Maintenance and Testing** **1 What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?** *The Campus has contracted Elwood Fire Protection to replace all heat detectors.* **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?**	01/29/2025

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	14.4.5.5.1 through 14.4.5.5.4. Two or more detectors shall be tested on each initiating circuit annually. Different detectors shall be tested each year. Table 14.4.2.2 Test Methods at (14)(d)(2), (3) and (4) shall be used for fixed-temperature nonrestorable heat detectors. Records shall be kept by the building owner specifying which detectors have been tested. Within 5 years, each detector shall have been tested. This deficient practice could affect all clients, staff and visitors. Findings include: Based on review of the "Heat Detectors" section of the fire alarm system inspection contractor's "Fire Alarm Report" documentation dated 06/14/23, 01/03/24 and 06/19/24 with the Administrator, the Director of Nursing, the Director of Maintenance and the Field Maintenance Supervisor during record review from 10:10 a.m. to 1:20 p.m. on 12/05/24, documentation of heat detector testing for facility heat detectors within the most recent twelve month period was not available for review. Review of contractor's 06/14/23, 01/03/24 and 06/19/24 inspection documentation indicated a total of nine fixed temperature heat detectors are installed in the facility none of which were tested within the most recent twelve month period. The 06/14/23, 01/03/24 and 06/19/24 inspection documentation stated each inspection was a "Visual Test Only" and none of the heat detectors had a "Zone/ID#" to report to the fire alarm system. Based on interview at the time of record review, the Director of Maintenance and the Field Maintenance Supervisor did not know if facility heat detectors were restorable or nonrestorable and agreed heat detector testing documentation for the most recent twelve month period was not available for review.		*This deficient practice could affect all residents, staff and visitors in the facility. The Campus has contracted Elwood Frie Protection to replace all heat detectors* **3. What measures will be putting place or what systemic changes will be made to ensure that the deficient practice does not occur?** *The Director of Maintenance was educated by the Executive Director on*K345 Fire Alarm - Mtn and Testing**.** Heat detectors need to be tested or replaced annually *This task has been added to the Tels building system for required timely testing. This task requires review of the deficiencies section and signature before documentation can be uploaded and task completed.* **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** *This Tels task will be reviewed by the Safety/QAPI committee Lead by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement Until 100% compliance is achieved.*	

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	These findings were reviewed with the Administrator, the Director of Nursing, the Director of Maintenance and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		**5. Date of Completion:** 1-29-25	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 5.3.1.1.1.6 states dry sprinklers that have been in service for 10 years shall be replaced or representative samples shall be tested and then retested at 10-year intervals. NFPA 25, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of the sprinkler system	K 0353	K353 Sprinkler System - Maintenance and Testing 1 What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice? Full Sprinkler head replacement to be completed. The Campus has reached out to two different sprinkler vendors to assess and quote the system for sprinkler head replacement. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect	06/29/2025

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	inspection contractor's letter dated 04/03/19 with the Administrator, the Director of Nursing, the Director of Maintenance and the Field Maintenance Supervisor during record review from 10:10 a.m. to 1:20 p.m. on 12/05/24, a total of six dry pendant sprinkler heads from the facility were sent to an off-site laboratory for 10-year testing. Review of laboratory testing results documentation dated 04/15/24, indicated two of the six sprinklers sent for testing were found to be "Abnormal-No waterflow" and three of the remaining four sprinklers sent for testing were listed as "Abnormal-Visual No Test" due to the "sprinkler condition of the received sample sprinkler". Based on interview at the time of record review, the Field Maintenance Supervisor stated he was not aware of the status of sprinkler replacement in the facility on or after 04/15/19 due to the change in ownership of the facility within the last few years and agreed sprinkler system replacement documentation on or after 04/15/19 was not available for review at the time of the survey. These findings were reviewed with the Administrator, the Director of Nursing, the Director of Maintenance and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		all residents, staff and visitors in the facility. The campus is obtaining quotes to replace sprinkler heads 3. What measures will be putting place or what systemic changes will be made to ensure that the deficient practice does not occur? The Director of Maintenance was educated by the Executive Director on K353 Sprinkler System - Mtn and Testing. Sprinkler systems are required to be tested timely and any deficiencies fixed promptly. This task has been added to the Tels building system for required timely testing. This task requires review of the deficiencies section and signature before documentation can be uploaded and task completed. 4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?	

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			This Tels task will be reviewed by the Safety/QAPI committee Lead by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement Until 100% compliance is achieved. 5. Date of Completion: Waiver filed 6/29/2025	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 1 of 5 smoke barrier walls were protected to maintain the fire resistance rating of the smoke barrier wall. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the corridor door set by the Medical Supply Room by the Main Dining Room. Findings include: Based on observations with the Administrator, the Director of Nursing, the Director of	K 0372	**K372 Subdivision of Building Spaces - Smoke Barrier Doors** **1 What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?** *A contractor has been scheduled to remove all the old foam and drywall. Add new drywall and fire caulk all penetrations with the approved rated caulk*	01/29/2025

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	Maintenance and the Field Maintenance Supervisor during a tour of the facility from 1:20 p.m. to 3:20 p.m. on 12/05/24, the annular space surrounding two separate sprinkler pipes and the annular space surrounding a four inch in diameter silver conduit each of which penetrated the attic smoke barrier wall above the corridor door set outside the Medical Supply Room by the Main Dining Room were not firestopped. The smoke barrier wall above the corridor door set was a concrete block wall and had a rectangular section of dry wall affixed to the attic wall above the corridor door set to cover an access opening to the adjoining smoke compartment in the attic. Foam was used at the edges of the drywall to seal the dry wall edges. Based on interview at the time of the observations, the Director of Maintenance and the Field Maintenance Supervisor stated documentation of the fire resistance rating/UL listing of the foam used to seal the drywall edges was not available for review and agreed the aforementioned openings in the smoke barrier wall above the corridor door set by the Medical Supply Room were not firestopped to maintain the fire resistance rating of the smoke barrier wall. These findings were reviewed with the Administrator, the Director of Nursing, the Director of Maintenance and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		**2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** *This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the corridor door set by the Medical Supply Room by the Main Dining Room. All fire wall penetrations will be fixed and fire caulk to meet regulations* : **3. What measures will be putting place or what systemic changes will be made to ensure that the deficient practice does not occur?** *The Director of Maintenance was educated by the Executive Director on **K**372 Subdivision of Building Spaces - Smoke Barrier. All fire wall penetrations require approved fire caulk to prevent the passage of fire and smoke. A fire wall inspection has been added to the Tels system for quarterly review. Visual inspections weekly for 24 weeks totaling 6 months Paper documentation will kept on weekly checks.*	

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			4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? This Tels task will be reviewed by the Safety/QAPI committee Lead by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement Until 100% compliance is achieved. **5. Date of Completion:** *1/29/2025*	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC Based on record review and interview, the facility failed to ensure 6 of 44 fire dampers in the facility were provided necessary maintenance in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years	K 0521	**K521 HVAC Heating and ventilation** **What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?** *A contractor will be obtained to replace/repair the non-working dampers* **2. How other residents have the**	01/29/2025

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	except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the fire damper inspection contractor's "Fire and Smoke Damper Inspection Report" documentation dated 03/24/22 with the Administrator, the Director of Nursing, the Director of Maintenance and the Field Maintenance Supervisor during record review from 10:10 a.m. to 1:20 p.m. on 12/05/24, a total of 44 fire dampers in the facility were inspected and tested within the most recent four year period. A total of six fire dampers failed 03/24/22 inspection and testing. Repair or replace documentation on or after 03/24/22 for the six fire damper locations which failed four year testing was not available for review at the time of the survey. The fire damper locations which failed 03/24/22 were listed as "Damper No. 22" which "is seized and needs replaced" and "Dampers No. 25, 26, 27, 36 and 37" each "failed due to rust and corrosion-Need Replaced". Based on interview at the time of record review, the Field Maintenance Supervisor agreed repair or replacement documentation on or after 03/24/22 for the six fire damper locations which failed four year testing was not available for review at the time of the survey.		**potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** *This deficient practice could affect all residents, staff and visitors* *A contractor will be obtained to replace/repair the non-working dampers* **3. What measures will be putting place or what systemic changes will be made to ensure that the deficient practice does not occur?** *The Director of Maintenance was educated by the Executive Director on K521 HVAC Heating and Ventilation Damper inspections are required and all deficiencies repaired promptly. This task has been added to the Tels building system for required timely testing. This task requires review of the deficiencies section and signature before documentation can be uploaded and task completed* **4. How the corrective action will be monitored to ensure the deficient practice will not recur**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155699	A. BUILDING 01 B. WING	12/05/2024

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	These findings were reviewed with the Administrator, the Director of Nursing, the Director of Maintenance and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		**i.e., what quality assurance program will be put into place?** *This Tels task will be reviewed by the Safety/QAPI committee* *Lead by the Executive Director and/or Maintenance Director.* *The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement Until 100% compliance is achieved.* **5. Date of Completion:** *1/29/2025*	
K 0522 SS=D Bldg. 01	NFPA 101 HVAC - Any Heating Device Based on observation and interview, the facility failed to ensure 1 of 1 dryer rooms was continuously provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for all staff in the vicinity of the room. This deficient practice could affect at least two staff in the Laundry. Findings include: Based on observations with the Administrator, the Director of Nursing, the Director of Maintenance and the Field Maintenance Supervisor during a tour of the facility from 1:20 p.m. to 3:20 p.m. on 12/05/24, one wall mounted	K 0522	**K522 HVAC All Heating Devices** **What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?** *The Maintenance Director repaired the fresh air intake vent. The vents now function as they required* **2. How other residents have the potential to be affected by the same deficient practice will be identified and**	12/23/2024

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	155699	A. BUILDING 01 B. WING	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF HARTFORD CITY	715 N MILL ST HARTFORD CITY, IN 47348

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	electrically powered Louvre system was installed in an outside wall behind the natural gas fired dryers in the dryer room area of the Laundry to provide the dryers with intake air from the outside. The mechanical arm to open and close the Louvre system automatically with dryer activation was disconnected from the motor for the Louvre system with the Louvre's in the fully closed position. When the dryers were turned on by Laundry staff, the Louvre's failed to open due to the mechanical arm being disconnected from the Louvre system. The Field Maintenance Supervisor attached the mechanical arm to the motor and the Louvre system opened with dryer activation. Based on interview at the time of the observations, the Director of Maintenance and the Field Maintenance Supervisor stated they did not know why the mechanical arm was disconnected, it could become disconnected again and agreed it could not be assured the natural gas fired dryers would be continually provided with combustion air taken directly from the outside. These findings were reviewed with the Administrator, the Director of Nursing, the Director of Maintenance and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		**what corrective action will be taken?** *This deficient practice could affect at least two staff in the Laundry. Vent has been repaired* **3. What measures will be putting place or what systemic changes will be made to ensure that the deficient practice does not occur?** *The Director of Maintenance was educated by the Executive Director on K522 HVAC all Dryer fresh air intake must function as required. task has been added to the Tels building system for weekly inspections. This task will auto populate weekly and is required to be signed off. The Director of Maintenance will perform daily inspections x4 weeks then weekly inspections x 20 totaling 6 months will be kept on paper audit.* **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** This Tels task will be reviewed by the Safety/QAPI committee Lead by the Executive Director and/or Maintenance Director. The results will be reviewed for	

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			patterns, trends and continued recommendations for process monitoring and improvement Until 100% compliance is achieved. **5. Date of Completion:** *12/23/2024*	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on observation and interview, the facility failed to ensure 1 of 1 automatic transfer switches was maintained in accordance with NFPA 110. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, Section 6.2.16.2 states two pilot lights with identification nameplates or other approved position indicators shall be provided to indicate the switch position. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Administrator, the Director of Nursing, the Director of Maintenance and the Field Maintenance Supervisor during a tour of the facility from 1:20 p.m. to 3:20 p.m. on 12/05/24, neither position indicator for the automatic transfer switch located in the main electrical room was illuminated to indicate the switch position. One pilot position was listed as "Normal" and the second pilot position was listed as "Emergency." Based on interview at the time of the observations, the Director of Maintenance stated the automatic transfer switch is operable but agreed neither position indicator for the automatic transfer switch was illuminated to indicate the switch	K 0918	**K918 – Electrical System – Essential Electric** **What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?** *The generator service provider Evapar has been called to replace the indicator lights that do not function.* **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** *This deficient practice could affect all residents, staff and visitors. Indicator lights will be replaced*	01/29/2025

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	position. These findings were reviewed with the Administrator, the Director of Nursing, the Director of Maintenance and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		**3. What measures will be putting place or what systemic changes will be made to ensure that the deficient practice does not occur?** *The Director of Maintenance was educated by the Executive Director on* K918 Electrical All *lights on transfer switch should work as required. Light check added to weekly generator inspection sheets* **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** *This Tels task will be reviewed by the Safety/QAPI committee* *Lead by the Executive Director and/or Maintenance Director.* *The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement Until 100% compliance is achieved.* **5. Date of Completion:**	

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