STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155377	A. BUILDING -- B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SEYMOUR CROSSING	707 S JACKSON PARK DR SEYMOUR, IN 47274

(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: 01/09/23 Facility Number: 000272 Provider Number: 155377 AIM Number: 100274710 At this Emergency Preparedness survey, Seymour Crossing was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 115 certified beds. At the time of the survey, the census was 68. Quality Review completed on 01/12/23 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. This submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. We respectfully request a desk review and ask that your office accept this plan as our facility's compliance. Please review the attachments provided with this plan of correction, which include audit and re-education tools. Please feel free to contact Jay Myers, Executive Director, should you need any additional information to support the desk review at 812-522-2419. Thank you for your consideration.	
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.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
John Myers	HFA	02/03/2023

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

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	The [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 this section are approved for incorporation by reference by the Director of the Office of the			

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	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. (x) TIA 12-3 to NFPA 101, issued October 22, 2013.			

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	(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, observation 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 residents, staff and visitors. Findings include: Based on review of the emergency generator inspection contractor's preventive maintenance inspection documentation dated 10/27/22 with the Maintenance Director and the Field Maintenance Supervisor during record review from 9:40 a.m. to 12:30 p.m. on 01/09/23, the emergency generator starting batteries were listed as "Batteries Failed". In addition, review of the inspection contractor's "Fuel Analysis Report" documentation dated 10/27/22 listed the results for annual diesel fuel sampling as "Fail" due to water contamination. Based on interview at the time of record review, the Maintenance Director stated the starting batteries still work, he is still able to start and run the generator, the facility has a work order for battery replacement and the starting batteries should be replaced tomorrow but agreed work order documentation for battery replacement was not available for review at the time of record review. In addition, the Maintenance Director stated they have added fuel to the diesel fuel storage tank since 10/27/22 but documentation of any investigation of diesel fuel sampling failure	E 0041	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Testing of the batteries and fuel will be done in a timely manner and reported in TELS. If at any time there is test failure the ED will be notified for immediate repair or replacement. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance director to test batteries and schedule fuel testing per regulation and report findings in TELS for later regulatory review. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance, the	01/31/2023

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	was not available for review at the time of the survey. Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:30 p.m. on 01/09/23, the facility has one diesel fired emergency generator located outside the building on the northeast side of the property near the service hall exit door. Manufacturer's documentation affixed to the emergency generator indicated it was diesel fuel fired, manufactured 08/10/15 and was rated at 275 kW. Documentation affixed to the starting batteries indicated the batteries were installed in December 2017. This finding was reviewed with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during the exit conference.		Maintenance Director will bring results of audit to monthly QA meeting for review and recommendation monthly for a period of not less than 12 months. Executive Director to complete random checks of TELS and audit reports, reporting findings to QA meeting for a period of not less than six months.	
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: 01/09/23 Facility Number: 000272 Provider Number: 155377 AIM Number: 100274710 At this Life Safety Code survey, Seymour Crossing was found not in compliance with Requirements for Participation 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	K 0000	This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. This submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. We respectfully request a desk review and ask that your office accept this plan as our facility's compliance. Please review the attachments provided with this plan of correction, which include audit and re-education tools. Please feel free to contact Jay Myers, Executive Director, should	

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	Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 115 and had a census of 68 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. The facility has three detached storage sheds which were not sprinklered. Quality Review completed on 01/12/23		you need any additional information to support the desk review at 812-522-2419. Thank you for your consideration.	
K 0222 SS=F 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, 19.2.2.2.6			

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	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 throughout by an approved, supervised			

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	automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 11 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 Section 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 all residents, staff and visitors if needing to exit the facility using main entrance lobby. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:30 p.m. on 01/09/23, the exit door at the main entrance lobby was marked as a facility exit with an exit sign and could be opened by entering a code into a keypad at the door. However, the code was not posted at the exit door. Based on interview at the time of the observations, the Maintenance Director stated the receptionist can release the door to open during normal business hours but the door is locked daily after 8:00 p.m. and agreed the keypad code to release the exit door to open was not posted at the keypad. This finding was reviewed with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during the exit conference.	K 0222	K222 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The D-wing center hall exit door has had a LSC 7.2.1.6.1 approved signage placed on it stating the doors can be opened in 15 seconds by pushing on the door, additionally lobby door has had sign posted with code to get in and get out of the building using the key code. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** A 100% inspection of all exit doors along with kitchen doors has been conducted to ensure compliance with K222 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance director to inspect all exit doors weekly to ensure compliance and means of egress for all residents staff and visitors, documenting results in TELS. **How the corrective action(s) will be monitored to ensure the**	01/31/2023

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 1 delayed egress locks were readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6. (b) The doors unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in		**deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance, the Maintenance Director will bring results of TELS Inspections to monthly QA meeting for review and recommendation monthly for a period of not less than 12 months. Executive Director to review TELS Reports weekly and complete random checks of doors and means of egress reporting findings to QA meeting for a period of not less than six months.	

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	letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect over two staff and visitors if needing to exit the facility by the exit door in the D Wing by Room 110. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:30 p.m. on 01/09/23, the exit door to the outside of the facility in the D Wing by Room 110 was marked as a facility exit with an exit sign. The door also had a keypad at the exit door to release the door to open. The code to release the door to open was posted at the exit door. The door was not marked as a delayed egress door with the necessary delayed egress signage. The door was a delayed egress door as the door released to open after pushing for 15 seconds. Based on interview at the time of the observations, the Field Maintenance Supervisor stated the door was a delayed egress door as well and agreed the door was not posted with the necessary delayed egress signage. This finding was reviewed with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting			

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	Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review, observation and interview; the facility failed to document annual testing for all battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency and Exit Lighting: Conduct a 90 minute operational test" documentation dated 04/24/22 with the Maintenance Director and the Field Maintenance Supervisor during record review from 9:40 a.m. to 12:30 p.m. on 01/09/23, annual battery operated light testing documentation for the most recent	K 0291	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Facility will begin documenting annual testing for all back up lighting in accordance with regulations. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** There were no resdents effected by alleged deficient practices. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance director to complete testing in accordance with regulations at all locations of battery operated lighting documenting in TELS findings and completion. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance, the Maintenance Director will bring results of audit to monthly QA	01/31/2023

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	twelve month period documented only one battery operated light location was tested for 90 minutes. The battery light at the "Generator Enclosure" was the only battery operated light documented as being tested annually for a minimum of 90 minutes within the most recent twelve month period. Review of Direct Supply TELS Logbook Documentation "Emergency and Exit Lighting: Check illumination of exit lighting and exit signs" for "30 seconds" indicated four battery operated lighting systems are installed in the facility including inside the emergency generator enclosure. Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:30 p.m. on 01/09/23, a total of four battery operated lighting systems were noted in the facility which included the emergency generator location, at the emergency transfer switch and in the corridor outside Room 701 and Room 713 and each battery operated lighting system illuminated when its respective test button was pushed multiple times. Based on interview at the time of record review and of the observations, the Maintenance Director and the Field Maintenance Supervisor agreed annual 90 minute testing documentation did not include all battery operated lighting system locations in the facility. This finding was reviewed with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		meeting for review and recommendation monthly for a period of not less than 12 months. Executive Director to complete random checks of testing and audit reports, reporting findings to QA meeting for a period of not less than six months.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing			

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	Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with the minimum number of spare sprinklers in a spare sprinkler cabinet on the premises for the types and temperature ratings of the sprinklers on the property. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents, staff and visitors.	K 0353	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** **No residents were found to be affected the alleged deficient practice** **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** A 100% inspection of all fire pendants with two new pendants ordered for the attic and the sidewall along with the ordering and replacement of the six pendants identified in the kitchen as needing replaced. facility respectfully requests waiver of pendants due to supplier unable to	05/01/2023

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	Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:30 p.m. on 01/09/23, sidewall sprinklers were installed at exterior canopies and attic type sprinklers were installed throughout the attic. No sidewall spare sprinklers and no attic spare sprinklers were stored in the spare sprinkler cabinet at the sprinkler system riser or on the premises. Based on interview at the time of the observations, the Maintenance Director and the Field Maintenance Supervisor agreed the spare sprinkler cabinet did not contain any sidewall spare or attic spare sprinklers. This finding was reviewed with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b) 2. 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 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. Section 5.2.1.1.1 states		deliver for eight to ten weeks. Waiver request is attached. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance director to inspect all pendants weekly for a period or no less than six months to ensure compliance with K353 and the safety of all residents, staff and visitors. Maintenance Director to report any needs related to repair or replacement immediately to Executive Director for immediate repair. Maintenance Director to present results of inspections monthly to QA Committee. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance, the Maintenance Director will bring results of weekly inspection audit to monthly QA meeting for review and recommendation for a period of not less than 6 months. In the event of less than 100% compliance each week maintenance director to immediately inform Executive Director in order to bring compliance back to 100%. Executive Director to report to the QA Committee for a period of no less than six months any time	

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	sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. 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 kitchen staff and visitors in the facility. Findings include: Based on review of the sprinkler system inspection contractor's "Form for Inspection, Testing and Maintenance of Dry Pipe Fire Sprinkler Systems" documentation dated 06/07/22 with the Maintenance Director and the Field Maintenance Supervisor during record review from 9:40 a.m. to 12:30 p.m. on 01/09/23, dry sprinklers in the kitchen were not listed as "Free of corrosion and physical damage" in Part II.A.4.b.2 of the 06/07/22 inspection report. The "Deficiency Summary" section of the 06/07/22 report stated "(6) dry pendants in the kitchen need to be replaced with anti-corrosion heads". Based on interview at the time of record review, the Maintenance Director stated the facility had been working with the contractor to replace the six		compliance is not at 100%.	

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	pendant sprinklers in the kitchen, they were scheduled to be replaced soon but agreed documentation to correct the 06/07/22 sprinkler system annual inspection deficiencies was not available for review at the time of record review. This finding was reviewed with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0362 SS=E Bldg. 01	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 Based on observation and interview, the facility failed to ensure corridor walls in 1 of 10 smoke	K 0362	**What corrective action(s) will be accomplished for those**	01/31/2023

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	compartments were constructed to resist the transfer of smoke. LSC 8.3.3.1 states fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage and sills shall be in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Openings Protectives. NFPA 80, 2010 Edition, Section 4.8.2.11 states for service counter fire doors, sills shall be provided as part of the fire door assembly. Section 4.8.2.2 states sills shall be constructed of noncombustible materials. Section 4.8.2.5 states for special-purpose horizontally sliding accordion or folding doors with frames having a jamb depth of 4 inches or less, the sill width shall be equal to the jamb depth. Section 5.2.5.2 states no open holes or breaks shall exist in surfaces of either the door or frame. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the main dining room. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:30 p.m. on 01/09/23, the main dining room was open to the corridor. The rolling fire door for the kitchen is in the west wall of the corridor wall for the main dining room. The rolling fire door served as the opening protective for the kitchen serving window for the dining area. The rolling fire door was constructed without a sill for a two inch section at the bottom of the north end of the rolling door. In addition, it could not be ensured the sill was constructed of noncombustible materials. All observations were made with the rolling fire door in the fully closed position. Based on interview at the time of the observations, the Maintenance Director agreed there was a two inch section of the sill missing at		**residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** the rolling fire door without a sill has had a sill added per regulation constructed of non-combustible materials. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance director to inspect rolling fire door weekly for four weeks, bi weekly for eight weeks then monthly for four months to ensure continued comp **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance, the Maintenance Director will bring results of audit to monthly QA meeting for review and recommendation monthly for a period of not less than 7 months. Executive Director to complete random checks of rolling door and audit reports, reporting findings to QA meeting for a period of not	

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	the bottom of the north end of the rolling door which would not resist the passage of smoke and it could not be ensured the sill was constructed of noncombustible materials. This finding was reviewed with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		less than seven months.	
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 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			

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	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 3 of over 50 corridor doors to resident sleeping rooms had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:30 p.m. on 01/09/23, the ceiling mounted track for the privacy curtain for the resident bed nearest the corridor door to resident Room 806, Room 825 and Room 914 was installed such that the privacy curtain was in the path of the swing of the corridor door. The privacy curtain was fully opened in each room and prevented the corridor door to each of the three resident sleeping rooms from fully closing and latching into the door frame. Based on interview at the time of the observations, the Maintenance Director agreed the privacy curtain in the aforementioned rooms	K 0363	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Rooms 806, 825, and 914 have all had the privacy curtains moved to ensure there is no impediment from closing. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have potential to be affected by alleged deficient practice. A 100% inspection of privacy curtains and doors was completed ensuring all close and latch appropriately **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	02/09/2023

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	were hung in the path of the swing of the corridor door to the room and would not ensure the door would close and latch into the door frame. This finding was reviewed with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		Weekly audits to be completed by the maintenance director or designee reporting any deficiencies to the Executive Director immediately for repair. All audits to be presented to QA Committee for review and recommendation. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance, the Maintenance Director will complete an audit resident room doors ensuring proper closure This audit will be completed 1 time per month for 12 months. The results of these audits will be reviewed by the CQI committee monthly and action plans will be developed as needed.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1)			

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	Describe any mechanical smoke control system in REMARKS. 1. Based on observation and interview, the facility failed to ensure 1 of 10 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 near the vicinity of the smoke barrier wall by Room 825 in the B Wing. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:30 p.m. on 01/09/23, the annular space surrounding a four inch in diameter horizontal sprinkler pipe which penetrated the attic smoke barrier wall above the corridor door set by Room 825 in the B Wing was not firestopped. In addition, part of the hole of the annular space for the sprinkler pipe penetration was filled with brick and mortar but holes were caused in the brick by the penetration of white, blue and black data cables through the smoke barrier wall which were not firestopped. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned openings in the attic smoke barrier wall were not firestopped to maintain the fire resistance rating of the smoke barrier wall. This finding was reviewed with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0372	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** There were no residents effected by the alleged deficient practice **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The annualizer space surrounding the four inch diameter horizontal sprinkler pipe which penetrated the attic barrier has had fire stop applied in order to be in compliance with regulation. Additionally the two ducts on D Wing have had covers placed over them that resist the transfer of smoke and fire per regulation. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance director to inspect fire barriers mothly repairing immediately those found not in compliance and reporting to the Quality Assurance Committee findings **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	02/17/2023

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	2. 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 two staff and visitors in the D Wing. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:30 p.m. on 01/09/23, HVAC ductwork had been removed from two former ceiling mounted air supply or air return grills in the corridor by Room 102 and Room 105 in the D Wing which exposed the attic above. Based on interview at the time of the observations, the Maintenance Director agreed the holes in the ceiling caused by the removal of HVAC ductwork did not ensure the D Wing ceiling smoke barrier was protected to maintain the fire resistance rating of the smoke barrier. This finding was reviewed with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during the exit		**into place?** To ensure compliance, the Maintenance Director will bring results of audit to monthly QA meeting for review and recommendation monthly for a period of not less than 12 months. Executive Director to complete random checks of smoke and fire barrier and audit reports, reporting findings to QA meeting for a period of not less than six months.	

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	conference. 3.1-19(b)			
K 0374 SS=D Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure doors in 1 of 1 attic smoke barrier walls in the D Wing would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility by the D Wing. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor	K 0374	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by alleged deficient practice **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The smoke barrier door in the attic above the corridor door set by room 102 in D wing has had the data wires removed allowing door to shut completely. **What measures will be put into**	02/14/2023

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(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
	during a tour of the facility from 12:30 p.m. to 2:30 p.m. on 01/09/23, the smoke barrier door in the attic above the corridor door set by Room 102 in the D Wing was propped in the fully open position. In addition, numerous data cables were run through the opening for the smoke barrier door which would would not ensure the door would fully self close to restrict the passage of smoke. Based on interview at the time of the observations, the Maintenance Director agreed the smoke barrier door in the attic above the corridor door set by Room 102 in the D Wing was propped in the fully open position with data cables being run through the door opening which did not ensure the door would restrict the movement of smoke. This finding was reviewed with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		**place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance director to conduct weekly tests of all smoke barrier doors ensuring functionality, reporting to executive director any issues immediately for replacement or repair. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Executive Director to review with QA Committee results of inspections monthly for a period of not less than six months noting any repairs or replacements that were made.	
K 0511 SS=F Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric 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 junction boxes in the attic above the main fire alarm control panel room was maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical	K 0511	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	02/10/2023

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	155377	A. BUILDING 01 B. WING	01/09/2023

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	wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:30 p.m. on 01/09/23, one of one electrical junction boxes mounted in the attic above the attic access door in the main fire alarm control panel room in the D Wing was without a cover which exposed the spliced electrical wiring in the junction box. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned electrical junction box location did not have its cover plate installed which exposed the spliced electrical wiring in the junction box. This finding was reviewed with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		the junction box mounted in the attic above the attic access door in the main fire alarm control panel room in the D wing has had a cover plate installed. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** A 100% inspection of all attic cover plates has been conducted to ensure compliance with K511 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance director to inspect cover plates weekly to ensure compliance and, document results in TELS. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance, the Maintenance Director will bring results of TELS Inspections to monthly QA meeting for review and recommendation monthly for a period of not less than 12 months. Executive Director to review TELS Reports weekly and complete random checks of doors and means of egress reporting findings to QA meeting for a period of not less than six months.	

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K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation and interview; the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance within the most recent four year period 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. The test and inspection frequency shall be every 4 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. Section 19.4.3 states full unobstructed access to the fire damper shall be verified and corrected as required. This deficient practice could affect all residents, staff and visitors.	K 0521	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The three separate fire dampers noted on the ceiling in HVAC duct work in the corridor on D hall have all been inspected with dates noted on each one. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** A 100% inspection of all fire dampers has been conducted to ensure compliance with K521 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance director to inspect all fire dampers monthly to ensure compliance , documenting results in TELS. **How the corrective action(s) will be monitored to ensure the**	02/10/2023

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	Findings include: Based on record review with the Maintenance Director and the Field Maintenance Supervisor from 9:40 a.m. to 12:30 p.m. on 01/09/23, documentation of fire damper inspections conducted within the most recent four year period was not available for review. Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:30 p.m. on 01/09/23, three separate fire dampers were noted on the ceiling in HVAC ductwork in the corridor in the D Hall. Documentation affixed to the fire dampers did not provide the date of the most recent inspection and necessary maintenance. Based on interview at the time of record review and of the observations, the Maintenance Director agreed documentation of fire damper inspections conducted within the most recent four year period was not available for review. This finding was reviewed with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		**deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance, the Maintenance Director will bring results of TELS Inspections to monthly QA meeting for review and recommendation monthly for a period of not less than 12 months.	
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			

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	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 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, observation and interview; the facility failed to maintain 1 of 1 emergency power supply systems (EPSS) in accordance with NFPA 110. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Section 8.3.1 states EPSS shall be maintained to ensure to a reasonable degree that the system is capable of supplying service within the time specified for the type and for the duration specified for the class. This deficient practice affects all residents, staff and visitors.	K 0918	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	01/31/2023

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	Findings include: Based on review of the emergency generator inspection contractor's preventive maintenance inspection documentation dated 10/27/22 with the Maintenance Director and the Field Maintenance Supervisor during record review from 9:40 a.m. to 12:30 p.m. on 01/09/23, the emergency generator starting batteries were listed as "Batteries Failed". In addition, review of the inspection contractor's "Fuel Analysis Report" documentation dated 10/27/22 listed the results for annual diesel fuel sampling as "Fail" due to water contamination. Based on interview at the time of record review, the Maintenance Director stated the starting batteries still work, he is still able to start and run the generator, the facility has a work order for battery replacement and the starting batteries should be replaced tomorrow but agreed work order documentation for battery replacement was not available for review at the time of record review. In addition, the Maintenance Director stated they have added fuel to the diesel fuel storage tank since 10/27/22 but documentation of any investigation of diesel fuel sampling failure was not available for review at the time of the survey. Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:30 p.m. on 01/09/23, the facility has one diesel fired emergency generator located outside the building on the northeast side of the property near the service hall exit door. Manufacturer's documentation affixed to the emergency generator indicated it was diesel fuel fired, manufactured 08/10/15 and was rated at 275 kW. Documentation affixed to the starting batteries indicated the batteries were installed in December 2017. This finding was reviewed with the Administrator,		Testing of the batteries and fuel will be done in a timely manner and reported in TELS. If at any time there is test failure the ED will be notified for immediate repair or replacement. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance director to test batteries and schedule fuel testing per regulation and report findings in TELS for later regulatory review. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance, the Maintenance Director will bring results of audit to monthly QA meeting for review and recommendation monthly for a period of not less than 12 months. Executive Director to complete random checks of TELS and audit reports, reporting findings to QA meeting for a period of not less than six months.	

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	the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with	K 0920	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practic** The extension cord has been removed, no residents were	01/31/2023

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	NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over 8 residents, staff and visitors in the vicinity of resident sleeping Room 701. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:30 p.m. on 01/09/23, a sleep apnea machine and a television were plugged into a power strip on the floor one foot from the upholstered chair in which a resident was sitting in resident sleeping Room 701. The UL listing of the power strip was 1363A. Based on interview at the time of the observations, the Maintenance Director and the Field Maintenance Supervisor agreed a power		affected by alleged deficient practice **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** A 100% audit of all resident rooms along with all offices was completed identifying those power cords which were deficient, all identified power cords were replaced. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance director to inspect all power cords brought into building before usage, additionally Maintenance director to complete monthly inspection of all rooms to ensure no extension cords have been brought in. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance, the Maintenance Director will bring results of audit to monthly QA meeting for review and recommendation monthly for a period of not less than 12 months. Executive Director to complete random checks of power cords and audit reports, reporting	

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	strip was being used in the patient care vicinity for PCREE and non-PCREE at the aforementioned location. 3.1-19(b)		findings to QA meeting for a period of not less than six months	