STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155582	A. BUILDING -- B. WING	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE	300 N WASHINGTON ST WAKARUSA, IN 46573

(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: 02/28/23 Facility Number: 000521 Provider Number: 155582 AIM Number: 100266980 At this Emergency Preparedness survey, The Waters of Wakarusa Skilled Nursing Facility was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 133 certified beds. 109 are dually certified for Medicare and Medicaid; 24 are certified for Medicare only. At the time of the survey, the census was 88. Quality Review completed on 03/06/23	E 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.** Please consider allowing paper submission of audits and education as evidence of compliance with the state and federal requirements identified in the survey. We respectfully request a paper review for compliance.	
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: 02/28/23	K 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
James Schmidt	Administrator	03/20/2023

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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	Facility Number: 000521 Provider Number: 155582 AIM Number: 100266980 At this Life Safety Code survey, The Waters of Wakarusa Skilled Nursing Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 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. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridors. 73 resident rooms were provided with battery operated smoke detectors. The facility is partially protected by a diesel-powered 230 kW emergency generator. The facility has 133 certified beds. 109 are dually certified for Medicare and Medicaid; 24 are certified for Medicare only. At the time of the survey, the census was 88. Quality Review completed on 03/06/23		**agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.** Please consider allowing paper submission of audits and education as evidence of compliance with the state and federal requirements identified in the survey. We respectfully request a paper review for compliance.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1			

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	155582	A. BUILDING 01 B. WING	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	1. Based on observation and interview, the facility failed to ensure 1 of 1 exit doors from the kitchen and beauty shop only contained one latching mechanism to release the door and open. LSC 7.2.1.5.10 states a latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions. 7.2.1.5.10.4 states the releasing mechanism shall open the door leaf with not more than one releasing operation. 7.2.1.5.10.1 states the releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches, above the finished floor. This deficient practice could affect staff and residents that use the kitchen and beauty shop. Findings include: Based on observation with the Maintenance Director and Executive Director on 02/28/23 between 1:20 p.m. and 3:40 p.m., one door leading into the kitchen and one leading into the dishwasher area were equipped with two latching devices, a latching door push handle and a separate deadbolt lock. Furthermore, the door leading into the beauty shop had a turn handle and separate deadbolt lock. Based on interview at the time of observations, the Maintenance Director agreed the three doors had two separate latching mechanisms. This finding was reviewed with the Maintenance Director and Executive Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 7 means of egress were	K 0211	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.** Please consider allowing paper submission of audits and education as evidence of compliance with the state and federal requirements identified in the survey. We respectfully request a paper review for compliance. **K211** – It is the intent of the facility to ensure exit doors only contain one latching mechanism to release the door and open and means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 3-17-23 the Maintenance Supervisor/designee	03/20/2023

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	continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect all staff and residents in the Rose Pod hall Findings include: Based on an observation during a tour of the facility with the Maintenance Director and Executive Director on 02/28/23 between 1:20 p.m. and 3:40 p.m., the Rose Pod hall exit corridor contained a lost & found clothing cart stored in the corridor. Based on an interview at the time of observations, the Executive Director stated that the cart is stored there permanently. The Executive Director moved the cart out of the corridor upon observation. The findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		removed one of the latching mechanisms from the door leading into the kitchen and the one leading into the dishwasher area and the door leading into the beauty shop to meet set standards. The Administrator verified the work on 3-17-23. b. On 3-1-23 the Maintenance Supervisor/designee removed the cart from the Rose pod hall exit corridor to meet set standards. The Administrator verified the work on 3-1-23 . 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 3-1-23 the Maintenance Supervisor/designee inspected all corridor means of egress and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 3-13-23 the Administrator Inserviced the Maintenance Supervisor/designee and all other staff on the requirement that exit doors only contain one latching mechanism to release the door and the corridor means of egress are to remain free of obstructions to meet set standards. b. Maintenance Supervisor/designee will ensure the exit doors only contain one latching mechanism to release the door and will inspect all corridor	

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			means of egress throughout the facility weekly for obstructions as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3-20-23.**	

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K 0293 SS=D Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on record review and interview; the facility failed to install exit signage in 1 of 2 corridors in the kitchen in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect staff and at least 5 kitchen staff. Findings include: Based on observation with the Executive Director and Maintenance Director on 02/28/23 between 1:20 p.m. and 3:40 p.m., the exit sign in the kitchen near the cooking area indicates occupants to egress right towards the dishwashing area. On observation, the dishwasher area had no emergency exit. Based on interview at the time of observation, the Executive Director acknowledged the aforementioned condition and confirmed that the path of egress was not obvious. This finding was reviewed with the Executive	K 0293	**K293**– It is the intent of the facility to ensure to provide and maintain exit signage in corridors in the kitchen in accordance with LSC 7.10 to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 3-15-23 the Maintenance Supervisor/designee repaired the exit sign in the kitchen to meet set standards. The Administrator verified the work on 3-16-23. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 3-13-23 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure to provide and maintain exit and directional exit signs to mark exit paths to reach the exits to meet set standards.	03/20/2023

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	Director and Maintenance Director at the exit conference. 3.1-19(b)		b. Maintenance Supervisor/designee will conduct a monthly check of all emergency exit signs and document those inspection results on the Emergency Lights & Signs Test Log as a part of the facility's Preventive Maintenance Program. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with**	

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			all regulatory requirements. Our date of compliance is 3-20-23.	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of 73 of 73 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on records review with the Maintenance Director on 02/28/23 between 09:50 a.m. and 1:14 p.m., no completed itemized list for preventative maintenance of resident room battery operated smoke alarms was available for review. The documentation provided dated inspections and	K 0300	**K300**– It is the intent of the facility to ensure documentation for the preventative maintenance of battery operated smoke alarms in resident rooms is complete to meet set standards. **1) CORRECTIVE ACTIONS TAKEN**: a) On 3-1-23 the Maintenance Supervisor/designee removed all the battery-operated smoke alarm batteries and replaced them with new 5 year Procel 9 volt batteries and dated the batteries and documented the installation on the battery operated smoke alarms and documented on the Battery-Operated Smoke Detector Maintenance Log to meet set standards. The Administrator verified the installation on 3-2-23. **2) ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a) All residents and all staff and visitors have the potential to	03/20/2023

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	cleanings, but did not document the times at which batteries were replaced in the smoke detectors. At interview during record review, the Maintenance Director stated they do not know when the batteries were changed last and should be changed annually. Findings were reviewed with the Executive Director and Maintenance Director at exit conference. 3.1-19(b)		be affected but none were. **3) MEASURES TO PREVENT REOCCURRENCE**: a) On 3-13-23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that battery operated smoke alarms must be maintained including the battery replacement dates and documentation retained at the facility to meet set standards. b) Maintenance Supervisor/designee will ensure to maintain the battery smoke alarms including the battery replacements per manufacturer's guidelines throughout the facility and document the results on the Battery-Operated Smoke Detector Maintenance Log to be filed in the Life Safety Binder as a part of the facility's Preventive Maintenance Program. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c) The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4) MONITORING CORRECTIVE ACTION**: a) The inspection results will be presented by the Maintenance Supervisor/designee to the	

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			Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3-20-23.**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9			

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	Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 1 utility storage rooms which is a hazardous area containing combustible storage and greater than 50 square feet was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could over 10 staff and residents in one smoke compartment. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Executive Director on 02/28/23 between 1:20 p.m. and 3:40 p.m., the utility storage room in Rose Pod, a hazardous storage room that was greater than 50 square feet, was equipped with self-closing device but did not latch into the frame when tested three times. Based on interview at the time of observation, the Maintenance Director and Executive Director agreed the room was used as storage, was larger than 50 square feet, and stated the self-closing hinges of the door need to be adjusted in order for the door to latch into the frame. The door was able to latch after fixing the	K 0321	**K321**– It is the intent of the facility to ensure the corridor doors to utility storage rooms which is a hazardous area containing combustible storage and greater than 50 square feet is provided with a self-closing device which would cause the door to automatically close and latch into the door frame to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 3-3-23 the Maintenance Supervisor/designee repaired the self-closing device on the utility storage room in Rose Pod so it latches into the frame to meet set standards. The Administrator verified the work on 3-13-23. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 3-1-23 the Maintenance	03/20/2023

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	latch during observation. Findings were discussed with the Executive Director and Maintenance Director at exit conference. 3.1-19(b)		Supervisor/designee inspected all hazardous areas for self-closing devices and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 3-13-23 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that all hazardous areas have self-closing devices and self-close and latch fully into the frame to meet set standards. b. Maintenance Supervisor/designee will inspect all hazardous area doors throughout the facility monthly to ensure they have self-closing devices and self-close and latch fully into the frame as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance	

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			Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3-20-23.**	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE	300 N WASHINGTON ST WAKARUSA, IN 46573

(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
	NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure staff had access to the shutoff switch for 1 of 1 cook tops in the activities room. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect five residents in the therapy gym. Findings include: Based on observation with the Maintenance Director and Executive Director on 02/28/23 between 1:20 p.m. and 3:40 p.m., there was a cooktop in the activities room that was separated from the corridor that had a shut off, but was not locked or restricted from unauthorized access.	K 0324	**K324**– It is the intent of the facility to ensure staff has access to the shutoff switch for cooktops in the activities room to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On 3-2-23 the Maintenance Supervisor/designee replaced the lock on the cooktop in the activities room to meet set standards. The Administrator verified the work on 3-2-23. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 3-13-23 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that all staff has access to the shutoff switch for cooktops to meet set standards. b. Maintenance Supervisor/designee will ensure all staff has access to the shutoff switch for cooktops as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator	03/20/2023

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	Based on interview at the time of observation, the Maintenance Director was unable to secure the switch and stated they will need to switch the lock. The finding was reviewed with Maintenance Director and Executive Director during the exit conference. 3.1-19(b)		the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3-20-23.**	
K 0341 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously			

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	occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was installed in accordance with 19.3.4.1. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 17.7.4.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 20 in one smoke compartment. Findings include: Based on observation with the Maintenance Director and Executive Director on 02/28/23 between 1:20 p.m. and 3:40 p.m., in the kitchen storage area near the dish cleaning area, there was a smoke detector next to an air return where air flow would prevent proper operation of the detector. The detector was a about 20 inches from the vent. Based on interview at the time of observation, the Executive Director agreed the smoke detector was in the direct airflow from the return and was within 20 inches of the vent. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)	K 0341	**K341** – It is the intent of the facility to ensure fire alarm systems are installed in accordance with 19.3.4.1 to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 3-13-23 the Certified Contractor/Maintenance Supervisor/designee moved the smoke detector to meet set standards. The Administrator verified the work on 3-13-23. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 3-1-23 the Maintenance Supervisor/designee inspected all other areas and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 3-13-23 the Administrator in serviced the Maintenance Supervisor/designee and all other staff on the requirement fire alarm systems are installed in accordance with 19.3.4.1 to meet set standards.	03/20/2023

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			b. Maintenance Supervisor/designee will inspect all fire alarm systems monthly to ensure they are in accordance with 19.3.4.1 as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with**	

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			all regulatory requirements. Our date of compliance is 3-20-23.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. Based on record review and interview, the facility failed to ensure all pull stations for 1 of 1 fire alarm systems were inspected, tested, and maintained in accordance with NFPA 72, National Fire Alarm Code. NFPA 72 Table Testing Frequencies 14.4.5.15(7)(m) requires water flow devices to be inspected and tested annually. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 02/28/23 at 10:50 a.m., the annual fire alarm report dated 07/14/22 indicated "Rose Pod" pull station was not tested "due to COVID". The semi-annual visual inspection later dated 1/21/23, had the pull station visually inspected, but was not listed as "passed." It was unable to be determined whether the pull station passed or failed inspection. Based on interview at the time of record review, the Maintenance Director agreed the pull station was not tested within the last year, and stated SafeCare will be contacted and should	K 0345	**K345**– It is the intent of the facility to ensure all pull stations and sensitivity on smoke detectors for fire alarm systems are inspected, tested and maintained in accordance with NFPA 72, National Fire Alarm Code and to ensure fire alarm systems are maintained in accordance with LSC 9.6.1.3 to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 3-10-23 a Certified Fire Alarm Contractor/designee conducted the semiannual visual inspection of the fire alarm system including pull stations and retained documentation in the facilities Life Safety Binder to meet set standards. The Administrator verified the work on 3-13-23. b. On 3-10-23 a Certified Fire	03/20/2023

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	have an appointment set up within the end of the day for inspection. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, Section 14.4.5.3.1 states smoke detector sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states smoke detector sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with Section 14.4.5.3.3. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 02/28/23 between 9:50 a.m. and 1:14 p.m., A sensitivity test had been conducted on 7/14/22, but the document titled "Smoke and Duct Detectors," five smoke detectors were not accessible or tested "No access due to COVID." When interviewed at the time of record review, the Maintenance Director stated they were unaware if the alarm company had completed the sensitivity testing for the remaining five detectors and would		Alarm Contractor/designee conducted the sensitivity test on the smoke detectors and retained documentation in the facilities Life Safety Binder to meet set standards. The Administrator verified the work on 3-13-23. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 3-13-23 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that semi-annual visual inspections of the fire alarm system must be conducted to meet set standards. b. Maintenance Supervisor/designee will ensure semi-annual visual inspections of the fire alarm system is conducted as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.	

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	contact the company by the end of the day. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3-20-23.**	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source			

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	Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to ensure 3 of 5 sprinkler heads in laundry area were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect all staff near the laundry area Findings include: Based on observation during a tour of the facility with the Maintenance Director and Executive Director on 02/28/23 between 1:20 p.m. and 3:40 p.m. 3 sprinkler heads located behind the dryer and in the laundry room showed heavy lint and dirt build-up. Based on interview at the time of observation, the Maintenance Director confirmed the aforementioned sprinkler heads showed dirt accumulation and loading and would start cleaning them after the survey. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)	K 0353	**K353** – It is the intent of the facility to ensure sprinkler heads in the laundry area are not loaded or covered with foreign material in accordance with LSC 9.7.5 and to ensure to maintain sprinkler system in accordance with 19.3.5.3 to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 3-1-23 the Maintenance Supervisor/designee cleaned the three sprinkler heads located behind the dryer and in the laundry room to meet set standards. The Administrator verified the work on 3-1-23. 2.On 3-10-23 the Maintenance Supervisor/designee confirmed that a certified sprinkler contractor performed the sprinkler inspection in 2019 and the documentation is filed in the Life Safety Binder to meet set standards. See attached report. The Administrator verified the work on 3-13-23. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**:	03/20/2023

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	2. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with 19.3.5.3. NFPA 25, 2011 Edition, 14.2.1 states except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 02/28/23 between 09:50 a.m. and 1:14 p.m., the sprinkler inspection from 12/20/22 stated the last inspection was completed in 2019, but had no inspection documentation to state whether it passed or failed inspection. Based on interview at the time of record review, the Maintenance Director agreed that documentation could not be found and would contact the sprinkler company. Findings were discussed with the Executive Director and Maintenance Director at exit conference. 3.1-19(b)		1.On 3-13-23 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that the sprinkler system must be properly maintained to meet set standards. 2.Maintenance Supervisor/designee will ensure the sprinkler heads are not loaded or covered with foreign material and will ensure required inspections of the sprinkler system are conducted as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by	

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			the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3-20-23.**	
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 and interview; the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance after the first year after instillation and at least every four years 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 be every 4 years 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	K 0521	**K521** – It is the intent of the facility to ensure all fire dampers in the facility area inspected and provided necessary maintenance after the first year after installation and at least every four years in accordance with NFPA 90A to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: 1.On 3-20-23 a Certified Contractor/designee started the inspection of the smoke/fire dampers in the facility to meet set standards; the inspection is scheduled and planned to be completed by March 24, 2023. The Administrator will verify the inspections were completed and will verify the documentation by	03/28/2023

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	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 deficiency could affect all residents and staff. Findings include: Based on records review with the Maintenance Director on 2/25/19 at 10:00 a.m., documentation of an inspection for the smoke/fire dampers in the facility was not available for review. Based on interview at the time of record review, the Maintenance Director stated that they could not find the damper inspection records, but knew there were dampers within the facility and the last inspection was 2018; which was overdue and would contact the contracted company to complete an inspection. Findings were reviewed with the Executive Director and Maintenance Director at exit conference. 3.1-19(b)		3-28-2023. **1.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **2.MEASURES TO PREVENT REOCCURRENCE**: 1.On 3-13-23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that smoke/fire dampers must be properly inspected and maintained to meet set standards. 2.Maintenance Supervisor/designee will ensure the smoke/fire dampers are properly inspected and maintained as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **3.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the	

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			Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3-28-23.**	
K 0522 SS=D Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms were 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	K 0522	**K522** – It is the intent of the facility to ensure laundry rooms are provided with intake combustion air from the outside for rooms containing fuel fired equipment to meet set standards.	03/20/2023

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	physical problems for all staff in the laundry room. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Executive Director on 02/28/23 between 1:20 p.m. and 3:40 p.m., the laundry room had fuel-fired dryers with a fresh air intake that was covered with lint and dirt. This condition does not allow for fresh air to completely enter the room. Based on an interview at the time of observation, the Maintenance Director stated the intake was covered with lint and would need to be cleaned. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)		**1.CORRECTIVE ACTIONS TAKEN**: 1.On 3-1-23 the Maintenance Supervisor/Laundry Department Employee/designee cleaned the fresh air intake to meet set standards. The Administrator verified the work on 3-1-23 and 3-17-23. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 3-13-23 the Administrator in serviced laundry staff, Maintenance Supervisor/designee on the requirement that the fresh air intake must remain free of lint and dirt to meet set standards. 2.Maintenance Supervisor/designee will ensure the fresh air intake is free of lint and dirt as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the	

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			Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3-20-23.**	
K 0761 SS=E Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 1 of 17 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed,	K 0761	**K761** – It is the intent of the facility to ensure annual inspection and testing of all fire door assemblies are completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies to meet set	03/20/2023

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	labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are		standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 3-2-23 the Maintenance Supervisor conducted the annual fire door inspection on the occupancy barrier between assisted living and healthcare and documented those inspection results on the Annual Door Inspections log to meet set standards. The Administrator verified the inspections and documentation on 3-15-23 . 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 3-13-23 the Administrator/corporate Property Manager inserviced the Maintenance Supervisor/designee on the requirement that annual testing & inspections of fire rated doors must be conducted to ensure proper operation and documented on the Annual Door Inspections log and maintained at the facility to meet set standards. b. Maintenance Supervisor/designee will conduct the annual door inspections to ensure proper operation and document the inspection results on the Annual Door Inspection log as a part of the facility's Preventive Maintenance Program and	

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	inspected to verify their presence and integrity. This deficient practice could affect 15 residents and staff in one smoke compartment. Findings include: Based on record review of the "Fire Door Inspection" documentation with the Maintenance Director on 02/28/23 at 10:05 a.m., the form listed smoke and fire door assemblies inspected annually. During review, the documentation did not include the occupancy barrier between assisted living and healthcare which had a 2-hour fire separation barrier. Based on observation during the tour between 1:20 p.m. and 3:40 p.m., there was a one and a half hour fire door assembly in an occupancy separation wall. Based on interview at the time of records review and observation, the Maintenance Director agreed and stated the separation door was not on the inspection list, was not inspected in the last year and confirmed the door was in a two hour separation fire barrier. Findings were discussed with the Executive Director and Maintenance Director at exit conference.		document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3-20-23.**	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric			

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	System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel	K 0918	**K918** – It is the intent of the facility to ensure to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for	03/20/2023

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	generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants. Findings include: Based on review of monthly generator load testing documentation with the Maintenance Director from 09:45 a.m. to 1:14 p.m. on 02/28/23, the load information to show the actual load percentage for the diesel-powered generator was documented and was less than 30%. Based on interview at the time of record review, the Maintenance Director acknowledged the generator ran under load on a monthly basis but does not achieve 30 % of the name plate rating. Additionally, the Maintenance Director did not provide documentation for an annual load bank. This finding was reviewed with the Maintenance Director and Executive Director at the exit conference. 3.1-19(b) 2. Based on record review and interview, the		Emergency and Standby Powers Systems, Chapter 8.4.2 and to ensure an annual fuel quality test is performed for the facility's diesel-powered generator and to ensure emergency generators are equipped with a properly located remote stop in the event the generator caught fire to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 5-17-22 the Facilities Certified Generator Contractor conducted the annual load bank test of the emergency generator and documented the results in the facilities Life Safety Binder to meet set standards. See attached report. b. On 5-17-22 the Facilities Certified Generator Contractor conducted the annual fuel quality test for the diesel generator and documented the results in the facilities Life Safety Binder to meet set standards. See attached report. c. On 3-1-23 the Maintenance Supervisor/designee posted a sign on the generator showing where the remote stop is located to meet set standards. See attached picture 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT**	

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	facility failed to ensure an annual fuel quality test was performed for 1 of 1 facility's diesel-powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on records review with the Maintenance Director on 02/28/23 between 09:50 a.m. and 1:14 p.m., no documentation of an annual fuel quality test for the diesel generator was available for review. Based on interview at the time of records review, the Maintenance Director stated they were unable to find documentation and would contact the servicer of the generator for documentation. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a properly located remote stop in the event the generator caught fire. NFPA 110, Standard for Emergency and Standby Power Systems 2010 Edition, Section 5.6.5.6, requires all installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building.		**REOCCURRENCE**: a. On 3-13-23 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that an annual load bank test of the emergency generator, annual fuel quality test, and a sign showing where the remote stop is located on the generator is required to meet set standards. b. The Maintenance Supervisor/designee will ensure an annual load bank test of the emergency generator, annual fuel quality test is conducted and documented in the life safety binder and will ensure there is an emergency stop identification in place to meet set standards. The Maintenance Supervisor/designee will ensure a sign is present showing there the remove stop is located on the generator to meet set standards. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance	

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	Section 5.6.5.6.1 requires the remote manual stop station to be labeled. Annex A is not a part of the requirements but is included for informational purposes only. A.5.6.5.6 states for systems located outdoors, the manual shutdown should be located external to the weatherproof enclosure and should be appropriately identified. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on observation on 02/28/23 between 1:20 p.m. and 3:40 p.m. with the Maintenance Director during a tour of the facility, a remote stop could not be located or seen when observing the generator. Upon interview at the time of observation, the Maintenance Director stated they were unaware of where the remote stop would be for the generator or if they had one. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3-20-23.**	
K 0920 SS=D 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			

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	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 1. Based on observation and interview, the facility failed to ensure 2 of 2 power cord daisy chains were not used as and as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. Article 400.8 (1) prohibits daisy chains, because the first extension cord (or power strip) is now acting as a substitute for the fixed wiring of a structure. This deficient practice could affect 1 staff in the Business Office. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Executive Director on 02/28/23 between 1:20 p.m. and 3:40 p.m., in the Business Office near the front entrance, a power strip was plugged into and supplied power by another power strip. Based on interview during the tour, the Maintenance Director acknowledged the aforementioned condition. The powerstrip was fixed and disconnected at observation. Findings were discussed with the Maintenance Director and Executive Director at exit conference.	K 0920	**K920** – It is the intent of the facility to ensure power cord daisy chains are not used as a substitute for fixed wiring and to ensure flexible cords are installed properly and used in a safe manner to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 3-1-23 the Maintenance Supervisor/designee removed the power strips from the Business office to meet set standards. The Administrator verified the removal on 3-1-23 and 3-17-23. 2.On 3-1-23 the Maintenance Supervisor/designee removed the power strip from the Social Services Office to meet set standards. The Administrator verified the removal on 3-1-23 and 3-17-23 **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. On 3-1-23 the Maintenance	03/20/2023

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could staff in the Social Service Office. Findings include: Based on observation with the Maintenance Director and Executive Director on 02/28/23 between 1:20 p.m. and 3:40 p.m., in the Social Services Office, a power strip used to power equipment, was not secured, and was dangling in front of a metal cabinet. This condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observations, the Maintenance Director agreed the power strip was dangling, not secured, and stated the power strip will need to be mounted or set on the floor. The powerstrip was fixed and secured at observation. This finding was reviewed with the Maintenance Director and Executive Director during the exit conference. 3.1-19(b)		Supervisor/designee inspected all rooms throughout the facility for power strips and found no other negative findings. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 3-13-23 the Administrator in serviced the Maintenance Supervisor/designee/all staff that power strips are not to be used as a substitute for fixed wiring to meet set standards. 2.Maintenance Supervisor/designee will inspect all rooms throughout the facility monthly to ensure they do not have power strips in use as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155582	A. BUILDING 01 B. WING	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE	300 N WASHINGTON ST WAKARUSA, IN 46573

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			inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3-20-23.**	