STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155258	A. BUILDING -- B. WING	12/07/2022

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

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E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 10/13/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/07/22 Facility Number: 000160 Provider Number: 155258 AIM Number: 100267190 At this PSR Emergency Preparedness survey, Countryside Manor Health and Living Community was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 109 certified beds. At the time of the PSR survey, the census was 62. Quality Review completed on 12/12/22	E 0000	December 20, 2022, Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: ZNIM22 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey Revisit conducted on December 7, 2022. This letter is to inform you that the plan of correction attached is to serve as Countryside Health & Living Community credible allegation of compliance. We allege substantial compliance on January 6, 2023. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 765-649-4558 Sincerely, Keeshan Patel, HFA	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keeshan Patel	Executive Director	12/21/2022

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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			Administrator Countryside Health and Living Submission of this plan of correction in no way constitutes an admission by Countryside Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
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)			

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	(e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by			

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	reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October			

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	22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on observations during a facility tour and interview with the Administrator on 12/07/22 between 12:15 p.m. and 2:45 p.m., the facility provided documentation for testing of the emergency generator, however, could not provide documentation of a three year 4 hour test. At the original survey, the Director of Maintenance stated that there was confusion with the contract with the new vendor and the past test was from 2018. At the PSR the Administrator stated he believed the test had been completed but not documentation was available for review. The finding was reviewed with the Administrator at the time of discovery and again during the exit conference. This deficiency was cited on 10/13/22. The facility failed to implement a systemic plan of correction to prevent recurrence.	E 0041	**E041** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The Community failed to ensure that the facility generator had a documented 4-hour load bank test. The previous test was from 2018 and needs to be completed every 3 years. Cummins Crosspoint completed the 4-hour load bank test on November 16. See attached copy of the load bank test. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and staff could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**	01/06/2023

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			Ongoing, the Administrator or designee will monitor the routine maintenance and operational testing program to ensure continued compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities has changed the contract with Cummins to include the load bank testing every 3 years. **V. Plan of Correction completion date.** Plan of Completion date is January 6, 2023	
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 10/13/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/07/22 Facility Number: 000160 Provider Number: 155258 AIM Number: 100267190	K 0000	December 20, 2022, Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance	

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	At this PSR Life Safety Code survey, Countryside Manor Health and Living Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in all resident sleeping rooms. The healthcare portion of the facility has a capacity of 109 and had a census of 62 at the time of this PSR visit. All areas where residents have customary access were sprinklered except for a garage and a shed which houses the generator and were not sprinklered. Quality Review completed on 12/12/22		Event ID: ZNIM22 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey Revisit conducted on December 7, 2022. This letter is to inform you that the plan of correction attached is to serve as Countryside Health & Living Community credible allegation of compliance. We allege substantial compliance on January 6, 2023. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 765-649-4558 Sincerely, Keeshan Patel, HFA Administrator Countryside Health and Living Submission of this plan of correction in no way constitutes an admission by Countryside Health and Living or its management company that the allegations contained in the survey report is a true and accurate	

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			portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of 8 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect 8 residents and staff using the Administrative Exit. Findings include: Based on observations during a facility tour and interview with the Administrator on 12/07/22 between 12:15 p.m. and 2:45 p.m., construction was underway but not complete on the exit	K 0271	**K 271** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The community failed to ensure that the exit discharge from the office area had a level walking surface. There is currently stairs at this location. Yoder Concrete has removed the stairs and installed an ADA complaint ramp	01/06/2023

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	discharge from the Administrative Office area, used primarily by administrative employees, which previously had 3 steps and was an uneven grade. The Administrator stated they got a late start on the project The finding was reviewed with the Administrator at the time of discovery and again during the exit conference. This deficiency was cited on 10/13/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		system to this location. See attached picture showing that this ramp has been constructed. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All office staff could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Ongoing, the Administrator or designee will monitor the walking surfaces of all exit discharges to ensure continued compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing **IV The facility will monitor the corrective action by implementing the following measures.** This correction is a final so there will be no long term follow up. **V. Plan of Correction completion date.** Plan of Completion date is January 6, 2023	

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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 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 maintain 1 of 3 corridor doors for cooking facilities that serve 30 or more residents to ensure cooking facilities are protected and not open to the corridor. This deficient practice affects 40 residents in the dining area. Findings include: Based on observations during a facility tour and interview with the Administrator on 12/07/22 between 12:15 p.m. and 2:45 p.m., the double set of corridor serving doors from the kitchen into the dining area failed to self-close and latch. The doors were held open with magnet holders and	K 0324	**K 324** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The community failed to ensure that a set of double doors in the kitchen leading to the dining hall were on self-closing hinges. The Maintenance Supervisor has locked one side of the door system down so it will not open.	01/06/2023

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	were integrated into the fire alarm system. The double serving doors were not equipped with a self-closing device or self-closing hinges. Serving stands were folded and stacked behind one of the two doors preventing the door from being held open by the magnetic holder. The finding was reviewed with the Administrator at the time of discovery and again during the exit conference. This deficiency was cited on 10/13/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		Spring hinges were added to the active side so it will automatically close when the fire system activates. See attached picture showing this door configuration. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All kitchen staff could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Ongoing, the Administrator or designee will monitor the door serving the kitchen into the dining area to ensure continuing compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing. **IV The facility will monitor the corrective action by implementing the following measures.** This is a permanent fix so no follow up will be needed. **V. Plan of Correction**	

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			completion date. Plan of Completion date is January 6, 2023	
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 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 observations during a facility tour and	K 0345	**K 345** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The community failed to ensure that a compliant smoke detector sensitivity test was available for review. Integrated Electronics completed the sensitivity test on December 12. See attached sensitivity test for your review. **II. The facility will identify other residents that may potentially be affected by the deficient practice.**	01/06/2023

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	interview with the Administrator on 12/07/22 between 12:15 p.m. and 2:45 p.m., no documentation for a complete current smoke detector sensitivity test was available for review. The Report dated 010/8/20 was the last sensitivity report and it stated the next would be due on 010/8/22, however no current documentation was provided. The Administrator stated that several emails had been exchanged between the facility and the contractor regarding the missing test. However, no reports were available for review. The finding was reviewed with the Administrator at the time of discovery and again during the exit conference. This deficiency was cited on 10/13/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		All staff and residents could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Ongoing, the Administrator or designee will monitor the operation of the fire alarm system and smoke detector sensitivity testing to ensure continued compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will monitor the testing frequency during their annual CQR inspections. **V. Plan of Correction completion date.** Plan of Completion date is January 6, 2023	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings,			

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	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 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 all corridor doors had no	K 0363	**K 363**	01/06/2023

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	155258	A. BUILDING 01 B. WING	12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 2 staff. Findings include: Based on observations during a facility tour and interview with the Administrator on 12/07/22 between 12:15 p.m. and 2:45 p.m., the following corridor doors failed to latch positively into their respective door frames: a) The "Staff" room across from resident room # 327, equipped with self-closing hinges. b) The Pantry door on the 300 hall equipped with a self-closing device hit the door jamb and did not close. The finding was reviewed with the Administrator at the time of discovery and again during the exit conference. This deficiency was cited on 10/13/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The Community failed to ensure three doors did not latch positively into their respective door frames. The Maintenance Supervisor has audited all doors in the community to ensure that they have latched. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Ongoing, the Administrator or designee will monitor corridor doors to ensure continued compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing. **IV The facility will monitor the corrective action by implementing the following measures.**	

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			CarDon Corporate Facilities will inspect all doors and latching devices during their annual CQR **V. Plan of Correction completion date.** Plan of Completion date is January 6, 2023	
K 0500 SS=E Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 3 of 3 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect 4 staff. Findings include: Based on observations during a facility tour and interview with the Administrator on 12/07/22 between 12:15 p.m. and 2:45 p.m., the facility's water heaters did not have current documentation to show when they were inspected. The certificates provided showed an expiration of 2019 for all the water heaters. The Director of	K 0500	**K 500** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The Community failed to ensure that the facility water heaters did not have current documentation to show when they were inspected. The insurance company inspected the water heaters on December 15th. See attached preliminary paperwork as we wait for the state to process our certificates. **II. The facility will identify**	01/06/2023

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	Maintenance stated that they are working with their insurance company to resolve the issues. The finding was reviewed with the Administrator at the time of discovery and again during the exit conference. This deficiency was cited on 10/13/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		**other residents that may potentially be affected by the deficient practice.** All staff and residents could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The maintenance supervisor was reeducated on when inspections for water heaters are due. **IV The facility will monitor the corrective action by implementing the following measures.** Ongoing, the Administrator or designee will monitor boiler and pressure operating permits to ensure continued compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing. **V. Plan of Correction completion date.** Plan of Completion date is January 6, 2023	
K 0918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste			

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Bldg. 01	Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power	K 0918	**K918** **I. The corrective actions to be accomplished for those**	01/06/2023

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	Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: Based on observations during a facility tour and interview with the Administrator on 12/07/22 between 12:15 p.m. and 2:45 p.m., the facility provided documentation for testing of the emergency generator, however, could not provide documentation of a three year 4 hour test. At the original survey, the Director of Maintenance stated that there was confusion with the contract with the new vendor and the past test was from 2018. At the PSR the Administrator stated he believed the test had been completed but not documentation was available for review. The finding was reviewed with the Administrator at the time of discovery and again during the exit conference. This deficiency was cited on 10/13/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		**residents found to have been affected by the deficient practice.** The Community failed to ensure that the facility generator had a documented 4-hour load bank test. The previous test was from 2018 and needs to be completed every 3 years. The Maintenance Supervisor has contracted with Cummins Crosspoint to do the 4-hour load bank test at their next scheduled service. Cummins Crosspoint completed the 4-hour load bank test on November 16. See attached copy of the load bank test. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and staff could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a current TELS task to have a 4-hour load bank test completed every 3 years. See attached TELS task labeled "Countryside Generator Maintenance"	

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			IV The facility will monitor the corrective action by implementing the following measures. CarDon Corporate Facilities is changing the contract with Cummins to include the load bank testing every 3 years. **V. Plan of Correction completion date.** Plan of Completion date is January 6, 2023.	