STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155473	A. BUILDING -- B. WING	11/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHALET VILLAGE HEALTH AND REHABILITATION CENTER	1065 PARKWAY ST BERNE, IN 46711

(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 State Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/29/17 Facility Number: 000546 Provider Number: 155473 AIM Number: 100267370 At this Emergency Preparedness survey, Chalet Village Health and Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 80 certified beds. At the time of the survey, the census was 27. Quality Review completed on 12/08/17-DA	E 0000	The creation and submission of this plan of correction does not constitute an admission by this provider or a conclusion set forth in the statement of deficiencies or any violation of regulation. Provider desires that the 2567 plan of correction be the letter of credible compliance and respectfully requests paper compliance in lieu of a re-visit. Respectfully Submitted, Melinda S. Hodgson, HFA Administrator	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by	K 0000	The creation and submission of this plan of correction does not	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/29/17 Facility Number: 000546 Provider Number: 155473 AIM Number: 100267370 At this Life Safety Code survey, Chalet Village Health and Rehabilitation Center 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 (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 80 and had a census of 27 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.		constitute an admission by this provider or a conclusion set forth in the statement of deficiencies or any violation of regulation. Provider desires that the 2567 plan of correction be the letter of credible compliance and respectfully requests paper compliance in lieu of a re-visit. Respectfully Submitted, Melinda S. Hodgson, HFA Administrator	

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	Quality Review completed on 12/08/17-DA			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General 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 maintain 2 of 68 corridor doors per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice affects 18 residents who reside on the 100 Hall and 200 Hall. Findings include: Based on observations on 11/29/17 during a tour of the facility from 9:40 a.m. to 12:44 p.m. with the administrator and maintenance supervisor, the 200 Hall storage room and the 100 Hall spa/bathroom each had two door knobs installed on the corridor doors with only the lower door knob on each door working as the functional device with attached latching hardware. Based on interview at the time of observations, the	K 0100	1.All Resident's have the potential to be affected 2.No Resident's were affected by the deficient practice 3.All non-functioning door knobs were removed and holes filled using fire caulking. 4.A facility wide inspection was completed on 11/30/2017 by the Maintenance Supervisor and found no other door that was affected. Maintenance staff was re-educated to only have 1 door knob with a positive latching system installed on corridor doors (see attachment) 5.Completion Date: 12/01/2017	12/01/2017

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	administrator and maintenance supervisor confirmed the upper door knobs were not functional. 3.1-19(b)			
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 in accordance with CMS Survey and Certification Letter 05-38. 18.2.7, 19.2.7, S&C 05-38 Based on observation and interview, the facility failed to ensure 1 of 8 exit discharges was constructed to prevent elevation changes in accordance with LSC 7.1.7. LSC 7.1.6.2 requires abrupt changes in elevation of walking surfaces shall not exceed 1/4 in. (6.3 mm). Changes in elevation exceeding 1/4 in. (6.3 mm), but not exceeding 1/2 in. (13 mm), shell be beveled with a slope of 1 in 2. Changes in elevation exceeding 1/2 in. (13 mm) shall be considered a change in level and shall be subject to the requirements of 7.1.7. This deficient practice affects 14 residents who use the activity room.	K 0271	1.All Resident's have the potential to be affected 2.No Resident's have been directly affected by the deficient practice. 3.A facility wide inspection was completed on 11/30/2017 and found that no other discharge/exit ramp had any cracks present. 4.Provider has repaired the concrete slab (see picture) 5.Completion date 12/22/2017.	12/22/2017

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	Findings include: Based on observation with the administrator and maintenance supervisor on 11/29/17 at 11:25 a.m., the activity room exit sidewalk surface had one inch elevation difference on the seven foot by four foot concrete slab where the sidewalk surface was broken and crumbling pieces were visible twelve feet from the exit door along the edge where the two concrete slabs came together. This was measured and confirmed by the maintenance supervisor and administrator at the time of observation. 3.1-19(b)			
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure continuity of egress lighting for 1 of 8 exits. For the purposes of this requirement, exit access shall include only designated stairs, aisle, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only	K 0281	1.All Resident's have the potential to be affected 2.No Residents were affected by the deficient practice 3.Exterior lights have been installed at the exit discharge sidewalk from the activity room. 4.Completion Date: 12/22/2017	12/22/2017

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	designated stairs, aisles, corridors, ramps, escalators, walkways and exit passageways leading to a public way. This deficient practice could affect up to 14 residents who use the activity room exit. Finding include: Based on observation on 11/29/17 at 11:25 a.m. with the administrator and maintenance supervisor, the exit discharge sidewalk from the activity room exit was not provided with lighting covering portions of the sidewalk from the exit to the public way parking lot. Based on interview at the time of observation, the maintenance supervisor confirmed there was no lighting fixtures along the activity room exit sidewalk where it discharged to the public way parking lot. 3.1-19(b)			
K 0293 SS=E 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 observation and interview, the	K 0293	1.All Resident's have the	12/22/2017

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	facility failed to ensure 1 of 8 exits was provided with an illuminated exit sign. LSC 7.10.1.2.1 requires 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 7.10.1.5.1 requires access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to all occupants. This deficient practice could affect 14 residents who use the activity room. Findings include: Based on observations on 11/29/17 at 11:25 a.m. with the administrator and maintenance supervisor, the activity room exit lacked an illuminated exit sign above the door. Furthermore, the floor plan provided during record review listed the activity room door as an exit. This was confirmed by the administrator and maintenance supervisor at the time of observation. 3.1-19(b)		potential to be affected 2.No Residents were affected by the deficient practice 3.A facility wide inspection was completed on 11/30/2017 by the Maintenance Supervisor and found no other exit affected 4.An illuminated exit sign has been installed above the exit door located inside the activity room 5.Completion Date: 12/22/2017	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire			

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	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. 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 Area Automatic Sprinkler Seperation 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 K3220) Based on observation and interview, the facility failed to ensure the corridor door to 1 of 4 hazardous areas, such as combustible storage rooms over 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 affect 16 residents who use	K 0321	1.All Resident's have the potential to be affected 2.No Residents were affected by the deficient practice 3.A facility wide inspection was completed on 11/30/2017 by the Maintenance Supervisor and found no other door to a storage area to be affected 4.A door closure was installed	12/22/2017

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	the main dining room located adjacent to the kitchen. Findings include: Based on observation on 11/29/17 at 11:03 a.m. with the administrator and maintenance supervisor, the kitchen food storage room, which measured one hundred thirty six square feet and stored twelve shelves of food supplies in plastic, paper and cardboard boxes, lacked a self closer on the door. This was confirmed by the administrator and maintenance supervisor at the time of observation. 3.1-19(b)		on the storage room identified in the 2567 5.Completion Date: 12/22/2017	
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			

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	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 record review, observation and interview, the facility failed to install the kitchen range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 edition, Section 10.4.1 states upon activation of any fire extinguishing system for a cooking operation, all sources of fuel and electrical power that produce heat to all equipment requiring protection by that system shall automatically shut off. 10.4.3 states any gas appliance not requiring protection but located under the same ventilating equipment shall also automatically shut off upon activation of any extinguishing system. 10.4.4 states shut off shall require manual reset. This deficient practice could affect 18 residents who use the main dining room located adjacent to the kitchen. Findings include:	K 0324	1.All Resident's have the potential to be affected 2.No Residents were affected by the deficient practice 3.All kitchen equipment was inspected on 11/30/2017 by the Maintenance Supervisor and found no other piece of equipment with a fuel source to be missing a fuel shut off valve 4.One should note, upon further inspection of the natural gas range there is a natural gas shut off valve located directly behind the unit. 5.Completion Date: 12/22/2017	12/22/2017

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	Based on observation with the administrator and maintenance supervisor on 11/29/17 at 12:20 p.m., the kitchen natural gas stove lacked a shut off valve. Based on record review on 11/29/17 at 10:20 a.m. with the administrator and maintenance supervisor, the two most recent hood extinguishing system inspection records from Elwood Fire Equipment Company dated 07/19/17 and 01/23/17 did not indicate a natural gas shut off switch was provided for the kitchen natural gas stove. Based on an interview with the maintenance supervisor at the time of observation, the maintenance supervisor stated the natural gas stove does not have a shut off valve. The lack of a natural gas shut off valve on the kitchen stove was confirmed by the administrator and maintenance supervisor at the time of observation. 3.1-19(b)			
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			

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	b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to ensure maintenance performed on the sprinkler system resulted in recommended repairs in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. LSC Section 9.7.5 requires all automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 12.2.1 states maintenance shall be performed to keep the system equipment operable or to make repairs. This deficient practice could affect all residents in the facility. Findings include: Based on record review on 11/29/17 at 10:15 a.m. with administrator and maintenance supervisor, the most recent sprinkler system inspection report labeled	K 0353	1.All Resident's have the potential to be affected 2.No Residents were affected by the deficient practice 3.The accelerator was repaired/replaced on 12/18/17 by Elwood Fire & Equipment Company. 4.Elwood Fire & Equipment Company inspected the sprinkler gauges and control valves on 10/20/17 as part of their quarterly maintenance, Elwood Fire & Equipment educated maintenance on 12/18/17 on completing the inspections of the sprinkler gauges (weekly) and control valves (monthly), a Preventative Maintenance form for weekly/monthly inspections have been provided to the Maintenance Supervisor. Maintenance Supervisor was re-educated on 11/30/2017 by the Administrator on inspecting sprinkler gauges weekly, and control valves monthly. (see attachment) 5.The following sprinkler heads have been **cleaned** and have been determined to be functional: (see pictures of areas identified)	12/22/2017

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	Elwood Fire Equipment Company Sprinkler System Test Report dated 10/20/17 indicated in the comment section "Accelerator not operational, failed to send fire alarm when we partially tripped tested. Control valve was at 1/4 open when tested. Recommend full trip during warm season. Fire alarm was received when tested through alarm test report." Based on an interview with the maintenance supervisor during record review, the maintenance supervisor stated a quote was received from Elwood Fire Equipment Company to rebuild or replace the accelerator and the work is to begin on 12/5/17. This was confirmed by the administrator at the time of record review and interview. 3.1-19(b) 2. Based on record review, observation and interview, the facility failed to document weekly and monthly sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry, preaction, and deluge systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire		1.The Laundry Room sprinkler behind the dryer was cleaned on 12/18/17 by Elwood Fire and Equipment Company 2.Resident Rooms 402, 404, 406, 408, 410, 412, 413, 414, 416, 203, and 211 sprinkler heads were all cleaned on 12/18/17 by Elwood Fire & Equipment Company 3.The main entrance foyer sprinkler that was covered in green corrosion was cleaned on 12/18/17 by Elwood Fire & Equipment Company. 6.The following sprinkler heads have been **replaced** on 12/18/17 & 12/21/17 by Elwood Fire and Equipment Company (see pictures of areas identified) 1.The 6 sprinklers in the dishwashing room were replaced on 12/21/17 by Elwood Fire & Equipment Company 2.The activity room sprinkler head that had a bent deflector has been replaced on 12/18/17 by Elwood Fire & Equipment Company 3.The main entrance overhang; consisting of 12 sprinklers were replaced on 12/18/17 by Elwood Fire & Equipment Company 4.The kitchen walk –in cooler sprinkler was ordered on 12/18/17 and will be replaced by Elwood Fire & Equipment Company. 7.7 of 7 fire hydrants have been inspected on 12/21/17 by Elwood Fire & Equipment Company and	

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	department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1.1 states valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. This deficient practice could affect all residents in the facility. Findings include: Based on record review with the maintenance supervisor and administrator on 11/29/17 at 9:40 a.m., the Elwood Fire Equipment Company Sprinkler System Test Reports dated 10/20/17, 07/19/17, 04/04/17, and 01/23/17 indicated the facility has a dry sprinkler system with two control valve, and three sprinkler gauges and they were visually inspected during each quarterly inspection. Based on an interview with the maintenance supervisor on 11/29/17 at 9:45 a.m., it was indicated the facility does not perform weekly inspections on the three sprinkler system gauges and monthly inspections on the two control valve. They are visually inspected during the quarterly sprinkler inspections. The lack of weekly sprinkler system gauges and monthly control valve inspections was confirmed by the maintenance supervisor and administrator at the time of record review and interview.		report provided (see attachment) 1.Elwood Fire & Equipment Company has scheduled this as part of their annual maintenance and inspection schedule for the fire system 8.Elwood Fire & Equipment Company has provided to the facility additional sprinkler heads that are now stowed in the spare sprinkler head cabinet. (See picture of the side mount sprinkler heads) 9.Completion date: 12/22/2017	

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	155473	A. BUILDING 01 B. WING	11/29/2017

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	3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 44 of over 300 sprinklers in the facility which were corroded, covered in rust, loaded or had physical damage were replaced. 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 residents in the facility. Findings include: Based on observations on 11/29/17 during a tour of the facility with the administrator and maintenance supervisor from 9:40 a.m. to 12:44 p.m., the following locations had sprinklers corroded, covered in rust, or showed signs of physical damage: a. The main entrance overhang had twelve			

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	sprinklers covered with brown rust. b. The main entrance foyer sprinkler was covered in green corrosion. c. The kitchen walk in cooler sprinkler was covered in brown rust. d. The kitchen had six sprinklers in the dishwashing room covered in green corrosion. e. The laundry room sprinkler behind the dryer was completely covered in dust. f. Resident rooms 402, 404, 406, 408, 410, 412, 413, 414, 416, 203, and 211 each had two sprinklers in the rooms covered in brown rust. g. The activity room sprinkler near the door had a bent deflector. The above listed sprinklers corroded, covered in rust, covered in dust, and a bent deflector were confirmed by the administrator and maintenance supervisor at the time of observations. 3.1-19(b) 4. Based on observation and interview, the facility failed to ensure 3 of 3 private fire hydrant was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2011 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Table 7.1.1.2			

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	requires wet and dry barrel hydrants to be inspected annually and after each operation. This deficient practice affects all residents in the facility. Findings include: Based on record review on 11/29/17 at 9:55 a.m. with the administrator and maintenance supervisor, the facility had three private dry fire hydrant outside the facility and the maintenance supervisor indicated there is no documentation of an annual inspection for the fire hydrants. The lack of an annual inspections for the three dry fire hydrants was confirmed by the administrator and maintenance supervisor at the time of record review. 3.1-19(b) 5. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler system was provided with spare sprinklers of each type located throughout the facility. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or			

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	damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect staff only who work in the Service Hall. Findings include: Based on observation on 11/29/17 at 10:36 a.m. with the administrator and maintenance supervisor, the Service Hall outside overhang had sidewall sprinklers mounted outside the exit door. Based on observation of the Service Hall spare sprinkler cabinet located in the main mechanical room on 11/29/17 at 10:50 a.m. with the administrator and maintenance supervisor, the spare sprinkler cabinet lacked spare sprinklers for the Service Hall outside overhang sidewall sprinklers. This was confirmed by the administrator and maintenance supervisor at the time of observation. 3.1-19(b)			

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K 0522 SS=C 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 18.5.2.2, 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 2 natural gas fired equipment rooms was provided with combustion air taken directly from the outside. This deficient practice could affect staff only who work in the Service Hall. Findings include: Based on observation with the administrator and maintenance supervisor on 11/29/17 at 11:15 a.m., the Service Hall boiler room had two natural gas boilers and two natural gas hot waters with a ten inch metal duct vented directly to the outside through the roof used for makeup combustion air. Furthermore, the ten inch makeup air duct was blocked with three, three inch plastic pipes which were used for combustion exhaust from the hot water heaters and boilers. This was	K 0522	1.All Resident's have the potential to be affected 2.No Resident's were affected by the deficient practice 3.The 3, three inch pipes that were vented to the outside have since been removed and properly vented to the exterior of the facility (see picture) 4.Completion date: 12/22/2017	12/22/2017

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	confirmed by the administrator and maintenance supervisor at the time of observation. 3.1-19(b)			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure fire drills were held on 1 of 3 shifts for 1 of 4 quarters over the past year and 2 of 12 fire drills over the past year included transmission of the fire alarm signal. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents, staff and visitors.	K 0712	1.All Resident's have the potential to be affected 2.No Resident's were affected by the deficient practice 3.The Maintenance Supervisor was re-educated on 11/30/2017 by the Administrator on the facility policy and procedure to testing the fire alarm monthly. The Maintenance Supervisor was provided with the facility policy and procedures to fire alarm testing and also a monthly schedule to ensure fire drills are conducted in accordance with K712.	12/22/2017

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	Findings include: Based on review of Monthly Fire Drill Records with the administrator and maintenance supervisor on 11/29/17 at 9:42 a.m., there was no record of a fire drill conducted on first shift for the first quarter of the year 2017. Furthermore, the fire drills held on 03/30/17 at 1:26 a.m., and 08/29/17 at 3:30 p.m. lacked documentation of the transmission of the fire alarm signal on the Monthly Fire Drill Records. Based on an interview with the maintenance supervisor at the time of record review, it was stated there was no other documentation available for review to indicate a fire drill was conducted on first shift for the first quarter of the year 2017 and the transmission of the fire alarm signal occurred on the 03/30/17 1:26 a.m. fire drill and the 08/29/17 3:30 p.m. 3.1-19(b)		4.The Maintenance Supervisor will complete monthly fire drill testing and then submit to the Administrator and Quality Assurance Committee the monthly fire drill report. The report will be inspected to ensure the alarm is sounded if during the day time hours, staff has participated in the fire drill by means of signing and that the fire drill are in accordance to the facility policy. Any deficient practice identified will be corrected immediately and staff re-education provided. (See attachment) 5.Completion date: 12/22/2017	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life			

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	safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. 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 ensure a written record of weekly inspections for the emergency generator set was maintained for 52 of the past 52 weeks. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the	K 0918	1.All Resident's have the potential to be affected 2.No Resident's were affected by the deficient practice 3.The Maintenance Supervisor was re-educated on 11/30/2017 by the Administrator on providing weekly documentation and monthly documentation during the weekly engine run of the generator and the monthly load test for the generator 4.The Maintenance Supervisor	12/22/2017

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	administrator and maintenance supervisor on 11/29/17 at 10:10 a.m., there was no record of weekly storage battery tests and weekly inspections of the emergency generator set for the past year. Based on a review of the Monthly Test Log during record review, the Monthly Test Log documented monthly load tests over the past year and was the only documentation available for review. The lack of weekly inspections of the emergency generator over the past year was confirmed by the administrator and maintenance supervisor at the time of record review. 3.1-19(b)		will during the weekly engine run, obtain readings from the generator panel and noting the readings on the generator form, during the monthly load test the Maintenance Supervisor will obtain readings from the generator panel while the generator is under a load and note the readings on the generator forms. The Maintenance Supervisor will then submit to the Administrator and Quality Assurance Committee for review. Any deficient practice identified will be corrected immediately. (see attachment) 5.Completion date: 12/22/2017	
K 0927 SS=B Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 2 of 2 oxygen	K 0927	1.All Resident's have the potential to be affected 2.No Resident's were affected	12/22/2017

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	storage/transfer locations were provided with signs indicating that transferring is occurring. NFPA 99 11.5.2.3.1(3) states, the area is posted with signs indicating that transfilling is occurring and that smoking is the immediate area is not permitted. This deficient practice could affect staff who work in the Service Hall and transfills liquid oxygen. Findings include: Based on observation on 11/29/17 at 11:25 a.m. with the administrator and maintenance supervisor, the Service Hall two outside liquid oxygen storage/transfer locations had three full 450 liter containers of liquid oxygen in room attached to the facility, and three full one hundred eighty liter containers stored in the fenced location next to the outside of the facility. Based on an interview with the administrator at the time of observation, the nursing staff fills the 450 liter containers with the one hundred eighty liter containers of liquid oxygen and transfers liquid oxygen from the 450 liter containers into small portable containers for resident use in the liquid oxygen room. Furthermore, the door to the liquid oxygen room and the fence around the other liquid oxygen storage location each lacked a sign indicating that transferring of oxygen occurs in these		by the deficient practice 3.All staff was re-educated on filling portable oxygen containers by the Administrator on 12/22/17. The re-education to the staff instructed them to ensure that the sign “transfer in progress” be placed on the door while they’re doing oxygen transfers/filling. Once completed the sign can be removed and stowed inside the transfer location until transferring occurs. 4.The Maintenance Supervisor or designee will complete weekly inspections of the transfer location to ensure the sign is present and observe staff utilizing the sign while they complete oxygen transfers. These inspections will continue weekly for 30-days then bi-weekly for 30-days then monthly thereafter until compliance is achieved. Results of these inspections will be presented to the Quality Assurance Committee for review and if any deficient practice is identified corrections will be made immediately. 5.Completion date: 12/22/2017	

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	locations. This was confirmed by the administrator and maintenance supervisor at the time of observation. 3.1-19(b)			