| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155359 | A. BUILDING -- B. WING | 01/24/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| MAJESTIC CARE OF FORT WAYNE | 7519 WINCHESTER RD FORT WAYNE, IN 46819 |

| (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 |
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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 01/24/23<br><br>Facility Number: 000250<br>Provider Number: 155359<br>AIM Number: 100289980<br><br>At this Emergency Preparedness survey, Majestic Care of Fort Wayne was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 66 and had a census of 60 at the time of this survey.<br><br>Quality Review completed on 01/25/23 | E 0000 | | |
| E 0041<br>SS=C<br>Bldg. -- | 482.15(e), 483.73(e), 485.625(e)<br>Hospital CAH and LTC Emergency Power<br>§482.15(e) Condition for Participation:<br>(e) Emergency and standby power systems.<br>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.<br><br>§483.73(e), §485.625(e)<br>(e) Emergency and standby power systems.<br>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. | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Gregg | Fuller | 02/06/2023 |

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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| | §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.<br><br>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.<br><br>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.<br><br>*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the 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 | | | |

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| | 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.<br>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.<br>(1) National Fire Protection Association, 1 Batterymarch Park,<br>Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.<br>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.<br>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.<br>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.<br>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.<br>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.<br>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.<br>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.<br>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.<br>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.<br>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.<br>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.<br>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, | | | |

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| | including TIAs to chapter 7, issued August 6, 2009.. | | | |
| | Based on records review and interview, the facility failed to implement the emergency power system 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.<br><br>Findings include:<br><br>Based on records review with the Administrator and Maintenance Director on 01/24/23 at 11:00 a.m., the generator lacked 3-year four hour load testing required by LSC and NFPA 110. Based on interview at the time of record review, the Maintenance Director stated the generator 3-year four hour load testing was not conducted.<br><br>The findings were reviewed with the Administrator and Maintenance Director at the exit conference. | E 0041 | 1. The required generator 4hr load test was completed.<br>2. No other concerns were identified<br>3. The Maintenance Director was educated on the requirement of a 3 year 4hr load test of the generator by the Executive Director. Maintenance Director will complete TELS for all required generator testing as assigned.<br>4. This will be reviewed by the Executive Director upon completion, and TELS will be reviewed weekly for completion of assigned audits. This information will be sent to QAPI for trending and completion follow-up.<br>5. 2/10/23 | 02/10/2023 |
| K 0000<br><br>Bldg. 01 | A Life Safety Code (LSC) Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 01/24/23<br><br>Facility Number: 000250<br>Provider Number: 155359<br>AIM Number: 100289980<br><br>At this LSC survey, Majestic Care of Fort Wayne was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR | K 0000 | | |

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| | 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.<br><br>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 66 and had a census of 60 at the time of this survey.<br><br>All areas where residents have customary access were sprinklered. All areas providing facilities services were sprinklered with the exception of a detached wood shed used for storage of maintenance supplies<br><br>Quality Review completed on 01/25/23 | | | |
| K 0300<br>SS=F<br>Bldg. 01 | NFPA 101<br>Protection - Other<br>Protection - Other<br>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.<br>Based on observation, record review, and interview the facility failed to ensure the 40 of 40 battery operated smoke alarms in resident rooms were replaced according to manufacturer's published instructions. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with | K 0300 | 1. The identified resident room smoke detectors were replaced with 10 yr Lithium Ion battery detectors.<br>2. No other detectors were identified.<br>3. The Maintenance Director | 02/10/2023 |

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| | 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. Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect all residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director and Administrator on 01/24/23 at 10:30 a.m., the battery-operated smoke alarms installed in resident rooms had a date of 04/17/12 written on the back of the smoke alarms. Based on records review at 10:30 a.m., the battery-operated smoke alarm manufacturer's published instructions stated, "replace alarm after ten years." Based on interview at the time of records review and observation, the Maintenance Director and Administrator agreed the smoke alarms were older than 10 years and needed to be replaced.<br><br>The finding was reviewed with the Administrator and Maintenance Director during the exit conference.<br><br>3.1-19(b) | | was educated on the requirement of 10 year replacement of battery operated smoke detectors by the Executive Director. Maintenance Director will complete TELS for 10 year smoke detector change as assigned.<br>4. This will be reviewed by the Executive Director upon completion, and TELS will be reviewed weekly for completion of assigned audits. This information will be sent to QAPI for trending and completion follow-up.<br>5. 2/10/23 | |
| K 0321<br>SS=E<br>Bldg. 01 | NFPA 101<br>Hazardous Areas - Enclosure<br>Hazardous Areas - Enclosure<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating | | | |

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| | (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.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms (exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K322) | | | |
| | Based on observation and interview, the facility failed to ensure 1 of 1 Combustible Storage Rooms/Spaces (over 50 square feet) were separated from other spaces by smoke resistant partitions or doors. This deficient practice could affect 25 residents in one smoke compartment.<br><br>Findings include:<br><br>Based on observations with the Maintenance | K 0321 | 1. The identified electrical room has the supplies stored in the room removed.<br>2. No other concerns were identified.<br>3. The Maintenance Director was educated on the requirement of proper supply storage by the Executive Director. Maintenance | 02/10/2023 |

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| | Director on 01/24/23 at 12:40 p.m., the door to the communication room was not smoke resistant. The communication room was provided with a door containing a vent from the corridor for cooling of equipment, was equipped with smoke detection, but the room also contained flammable items such as aerosol cans and painting supplies making the room a hazardous area. Based on interview at the time of the observation, the Maintenance Director agreed there was a vent in the door, the room did contain flammable items, and stated the flammable items will be removed from the room.<br><br>This finding was reviewed with the Administrator and Maintenance Director at the exit conference.<br><br>3.1-19(b) | | Director will complete weekly rounds in the electrical rooms for placement of supplies that do not meet code.<br>4. This will be reviewed by the Executive Director/designee weekly for 4 weeks, monthly for 4months for any supplies stored in the electrical room. This information will be sent to QAPI for trending and completion follow-up.<br>5. 2/10/23 | |
| K 0511<br>SS=E<br>Bldg. 01 | NFPA 101<br>Utilities - Gas and Electric<br>Utilities - Gas and Electric<br>Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.<br>18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2<br>Based on observation and interview, the facility failed to ensure 1 of 2 electrical boxes in in the east wing T.V. room was securely fastened in place. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. Article 406.5 states Receptacles shall be mounted in boxes or assemblies designed for the purpose, and such boxes or assemblies shall be securely fastened in place unless otherwise permitted elsewhere in this Code. This deficient practice could affect 20 residents in one | K 0511 | 1. The identified plug was replaced and supported.<br>2. No other plugs were found to have concerns.<br>3. The Maintenance Director was educated on the requirement of securing electrical plugs in the wall by the Executive Director. Maintenance Director will complete weekly rounds in lounge/corridors for loose plugs. | 02/10/2023 |

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| | smoke compartment.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director on 01/24/23 at 11:48 a.m., in the east wing T.V. room there was an electrical outlet box hanging out from the wall. Based on interview at the time of observation, the Maintenance Director agreed the electrical outlet box was not fastened securely to the wall and would need to be remounted.<br><br>This finding was reviewed with the Administrator and Maintenance Director during the exit conference.<br><br>3.1-19(b) | | 4. This will be reviewed by the Executive Director/designee weekly for 4 weeks, monthly for 4months for any blocked vents in the laundry room. This information will be sent to QAPI for trending and completion follow-up.<br>5. 2/10/23 | |
| K 0522<br>SS=E<br>Bldg. 01 | NFPA 101<br>HVAC - Any Heating Device<br>HVAC - Any Heating Device<br>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:<br>* is chimney or vent connected.<br>* takes air for combustion from outside.<br>* provides for a combustion system separate from occupied area atmosphere.<br>19.5.2.2<br>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 | 1. The identified laundry vent had the cardboard removed.<br>2. No other vent concerns were identified.<br>3. The Maintenance Director and Environmental staff was | 02/10/2023 |

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| | physical problems for all staff in the laundry room.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director on 01/24/23 at 12:15 p.m., the laundry room had fuel-fired dryers with a fresh air intake that was covered with cardboard. This condition does not allow for fresh air to enter the room. Based on an interview at the time of observation, the Maintenance Director agreed the air intake was covered and removed the cardboard.<br><br>This finding was reviewed with the Administrator and Maintenance Director at the exit conference.<br><br>3.1-19(b) | | educated on the requirement of not blocking vents in the laundry room by the Executive Director. Maintenance Director will complete weekly rounds in laundry with routine lent checks for blocked vents.<br>4. This will be reviewed by the Executive Director/designee weekly for 4 weeks, monthly for 4months for any blocked vents in the laundry room. This information will be sent to QAPI for trending and completion follow-up.<br>5. 2/10/23 | |
| K 0761 SS=E Bldg. 01 | Based on records review and interview the facility failed to ensure annual inspection and testing of 2 of 2 fire door assemblies were completed in accordance with LSC 19.1. and with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives. 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, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. 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. | K 0761 | 1. The annual door inspection was completed by Safe Care on 2/2/2023<br>2. All doors inspected.<br>3. The Maintenance Director was educated on the requirement of annual door inspections by the Executive Director. Maintenance Director will complete TELS for annual door inspection as assigned.<br>4. This will be reviewed by the Executive Director upon completion, and TELS will be reviewed weekly for completion of assigned audits. This information will be sent to QAPI for trending and completion follow-up.<br>5. 2/10/23 | 02/10/2023 |

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| | NFPA 80, Section 5.2.4.2 states as a minimum, the following items shall be verified:<br>(1) No open holes or breaks exist in surfaces of either the door or frame.<br>(2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.<br>(3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.<br>(4) No parts are missing or broken.<br>(5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.<br>(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.<br>(7) If a coordinator is installed, the inactive leaf closes before the active leaf.<br>(8) Latching hardware operates and secures the door when it is in the closed position.<br>(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.<br>(10) No field modifications to the door assembly have been performed that void the label.<br>(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity.<br>This deficient practice could affect 25 residents in 2 smoke compartments.<br><br>Findings include:<br><br>Based on record review with the Administrator and Maintenance Director on 01/24/23 at 11:00 a.m., the annual fire door inspections for the oxygen trans-filling room and the therapy fire doors were past due. The annual fire door inspection documentation available for review was from 2019. No other documentation was | | | |

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| | 155359 | A. BUILDING 01<br>B. WING | 01/24/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| MAJESTIC CARE OF FORT WAYNE | 7519 WINCHESTER RD<br>FORT WAYNE, IN 46819 |

| (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 |
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| | available to show the facility's fire doors were inspected within the last 12 months. Based on interview at the time of records review, the Administrator and Maintenance Director stated the annual fire door inspections were past due.<br><br>The finding was reviewed with the Administrator and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | | | |
| K 0914 SS=F Bldg. 01 | NFPA 101<br>Electrical Systems - Maintenance and Testing<br>Electrical Systems - Maintenance and Testing<br>Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.<br>6.3.4 (NFPA 99) | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | Based on observation, record review and interview, the facility failed to ensure non-hospital grade electrical receptacles at 40 of 40 resident sleeping rooms were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents.<br><br>Findings include:<br><br>Based on observations with the Maintenance Director on 01/24/23 between 12:00 a.m. and 2:00 p.m., the facility's 40 resident sleeping rooms contained four to eight non-hospital-grade electrical receptacles. Based on records review at 11:30 a.m., no documentation was available to show the last time the electrical receptacles in resident sleeping rooms were tested. Based on interview at the time of the observation and records review, the Maintenance Director confirmed all the electrical receptacles in the resident sleeping rooms were not hospital-grade and stated the testing was started but only 12 rooms have been tested. | K 0914 | 1. The identified receptacles were tested for proper function.<br>2. No other receptacles were identified.<br>3. The Maintenance Director was educated on the requirement of annual receptacle inspections by the Executive Director. Maintenance Director will complete TELS for annual receptacle check using the TELS Receptacle Check Form.<br>4. This will be reviewed by the Executive Director upon completion, and TELS will be reviewed weekly for completion of assigned audits. This information will be sent to QAPI for trending and completion follow-up.<br>5. 2/10/23 | 02/10/2023 |

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| | This finding was reviewed with the Administrator and Maintenance Director during the exit conference.<br><br>3.1-19(b) | | | |
| K 0918<br>SS=F<br>Bldg. 01 | NFPA 101<br>Electrical Systems - Essential Electric Syste<br>Electrical Systems - Essential Electric System Maintenance and Testing<br>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.<br>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 | | | |

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| | emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>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 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.<br><br>Findings include:<br><br>During records review with the Maintenance Director and Administrator on 01/24/23 at 10:59 a.m., documentation of a four-hour run test for the emergency generator conducted within the last 36 months was not provided for review. Based on interview at the time of records review, the Maintenance Director and Administrator stated a four-hour continuous run under load was not conducted in the past 36 months.<br><br>This finding was reviewed with the Administrator and Maintenance Director at the exit conference.<br><br>3.1-19(b) | K 0918 | 1. The required generator 4hr load test was completed.<br>2. No other concerns were identified<br>3. The Maintenance Director was educated on the requirement of a 3 year 4hr load test of the generator by the Executive Director. Maintenance Director will complete TELS for all required generator testing as assigned.<br>4. This will be reviewed by the Executive Director upon completion, and TELS will be reviewed weekly for completion of assigned audits. This information will be sent to QAPI for trending and completion follow-up.<br>5. 2/10/23 | 02/10/2023 |