DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING -- B. WING	12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/13/23 Facility Number: 000563 Provider Number: 155766 AIM Number: 100267610 At this Emergency Preparedness survey, Maple Manor Christian Home Inc. was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 57 certified beds. At the time of the survey, the census was 46. Quality Review completed on 12/19/23 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Steven Cunningham	Administrator	01/09/2024

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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	*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients			

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	and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing			

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participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm

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	systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the			

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	CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d)(1). This deficient practice could affect all occupants. Findings include: Based on review of "Disaster Plan" documentation dated 01/23/23 with the Administrator and the Maintenance Director during record review from 10:45 a.m. to 1:45 p.m. on 12/13/23, documentation for staff training on emergency preparedness within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Administrator stated new hires are trained on emergency preparedness based on employee handbook requirements, existing staff are regularly trained on individual facility policies like infection control but agreed annual staff training documentation on the emergency preparedness program conducted within the most recent twelve month period was not available for review at the time of the survey. These findings were reviewed with the Administrator during the exit conference.	E 0037	The deficient practice of not training staff on the emergency preparedness will be corrected by 12/31/2023. We have as high priority in our emergency plan and facility assessment Fire, Tornado and Active Intruder. I did in-services on tornado on March 21 and 23, 2023 and fire on June 13 and 15. I have included those in my packet of papers I am sending to you. The active intruder will be completed by 12/31/2023. I have attached pages 1-26 to show the in-service for the Active Intruder done the week of December 26-29. The employees that have not signed off are either on Medical leave, part-time or PRN, they will be in-serviced the next time they are at work. Addendum: During orientation of new employees our HR department trains the new employee on the initial emergency training during the orientation of the new employee which is part of our Employee Handbook. I have attached the material gone over in orientation and the tests (pages 1-26) that the new orientee completes to demonstrate the knowledge that they have received. I have attached the signature page that the new employee signs at the time of receiving the Employee Handbook	12/31/2023

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			and the emergency training that is given at the time of orientation, that is page 27 in the packet that is attached. I have also attached the material that is used to test our employees on the emergency training through out the year and the testing that is used to demonstrate the knowledge that they have received, that is also pages 1-26 in the packet that is attached. The test that we use to demonstrate the knowledge that the employees have learned are pages 8, 21, 25 and 26 in the packet that I have attached,	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. 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			

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

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	http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on record review, observation, and interview; the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health	E 0041	The deficient practice of not doing the weekly generator inspection documentation has been corrected on 12/27/2023. The Maintenance	12/27/2023

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	Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of "Maintenance Log-Emergency Generator" documentation with the Administrator and the Maintenance Director during record review from 10:45 a.m. to 1:45 p.m. on 12/13/23, the following was noted: a. weekly emergency generator inspection documentation for one week in March, April and August 2023 and a two week period in September 2023 was not available for review. Based on interview at the time of record review, the Maintenance Director stated the facility has one natural gas fired emergency generator and stated he performs visual inspections on a weekly basis. b. thirty-six month period emergency generator testing documentation for four continuous hours for the facility's natural gas fired emergency generator was not available for review. Based on interview at the time of record review, the Administrator stated the facility has one natural gas fired emergency generator. Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 1:45 p.m. to 3:30 p.m. on 12/13/23, a remote emergency stop button was located on the exterior of the building remote from the weatherproof shell for the emergency generator, but the remote emergency stop button was not labeled. The natural gas fired emergency generator for the facility located outside the building had an affixed nameplate indicating the		worker trained the Administrator on what to check and how to document what is checked. Going forward the Maintenance worker will make sure that the generator will be inspected and documented each week. In the event that he is off during a week the Administrator will do the inspection and documentation. The deficient practice of not running the generator for 4 hours at least every 36 months has been resolved on 12/27/2023. The Maintenance worker and/or his designee will make sure that this test is done at least every 36 months. I have attached pages 27-30 to show the work and training done on December 27, 2023.	

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	generator was rated at 35 kW. Based on interview at the time of record review, the Administrator and the Maintenance Director agreed weekly generator inspection documentation for the five week period in 2023 and thirty-six month period emergency generator testing documentation for four continuous hours was not available for review. Based on interview at the time of the observations, the Administrator and the Maintenance Director agreed the remote manual stop station was not labeled. These findings were reviewed with the Administrator during the exit conference.			
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/13/23 Facility Number: 000563 Provider Number: 155766 AIM Number: 100267610 At this Life Safety Code survey, Maple Manor Christian Home Inc 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 with a partial basement was	K 0000		

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	determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection on all levels including the basement, the corridors, spaces open to the corridors and has hard wired smoke detectors in resident rooms 300, 301, 302, 303, 304, 305, 306, 307, 308. The facility has battery operated smoke alarms in the remaining resident sleeping rooms. The facility has a capacity of 57 and had a census of 46 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 12/19/23			
K 0211 SS=F Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1			
	Based on observation and interview, the facility failed to ensure 2 of 9 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect all residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the	K 0211	The deficient of means of egress not being maintained free from all obstructions were resolved on 12/14/2023. The Administrator and Maintenance before they left the building on 12/14/2023 for the evening made sure that the 2 two egresses that were in question were cleared and free from obstruction. In the future the Administrator. Maintenance worker and/or his designee will	12/14/2023

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	facility from 1:45 p.m. to 3:30 p.m. on 12/13/23, furniture and upholstered chairs were positioned opposite one another on both sides of the corridor at the main entrance lobby which limited the eight foot wide corridor to a path of six feet nine inches in width as measured with a measuring tape. None of the furniture or chairs was affixed to the floor or to the wall. In addition, two wheeled carts for isolation supplies were stored opposite one another on both sides of the corridor outside resident Room 302 which limited the path of egress to four feet wide as measured with a measuring tape. Based on interview at the time of the observations, the Administrator agreed the aforementioned means of egress was not continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b)		make sure that the means of egress are free from all obstructions on a daily basis. Addendum: Attached is the form that will be used to make sure this is accomplished daily. You can find the form on page 28 of the packet that I attached.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all			

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	155766	A. BUILDING 01 B. WING	12/13/2023

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	locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS			

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	LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 1 of 8 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 10 residents, staff and visitors if needing to exit the facility by Room 308. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 1:45 p.m. to 3:30 p.m. on 12/13/23, the exit door to the outside of the facility by resident Room 308 was marked as a facility exit with an exit sign. The door could be opened by entering a four digit code into a keypad at the exit door but the code was not posted to release the door to open. Based on interview at the time of the observations, the Administrator stated residents with a clinical diagnosis requiring specialized security measures do not reside in the 300 wing and agreed the code to release the exit door to open was not posted at the exit door.	K 0222	The deficient practice of not having the code posted at the door in order for the exit to opened was resolved on 12/14/2023. The Administrative Assistant and/or her designee will check to make sure each exit will have the correct 4 digit code instruction posted by the keypad. The Administrative Assistant and/or her designee will check each week to make sure that the code is posted by the keypad at each exit. The Administrative Assistant and/or her designee will have a form to initial showing that this task is completed each week. I have attached page 31 that shows our form the the Administrative Assistant and/or her designee will use to sign off that the code at each door has been checked.	12/14/2023

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	These findings were reviewed with the Administrator during the exit conference. 3.1-19(b)			
K 0311 SS=F Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box.			
	Based on observation and interview, the facility failed to ensure the protection of 2 of 2 former dumbwaiters was in accordance with 19.3.1. LSC 19.3.1.1 states where enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating. LSC 8.3.4.2 states the fire protection rating for opening protectives shall be in accordance with Table 8.3.4.2 except as otherwise permitted in 8.3.4.3 or 8.3.4.4. Table 8.3.4.2 requires fire door assemblies in vertical shafts, including stairways, to have a 1-hour fire resistance rating. LSC 8.3.4.3 states existing fire door assemblies having a minimum ¾-hour fire protection rating shall be permitted to continue to be used in vertical openings and exit enclosures in lieu of the minimum 1-hour fire protection rating required in Table 8.3.4.2. This deficient practice could affect all residents, staff, and visitors. Findings include:	K 0311	The deficient practice of not having open shafts in the basement not being separated from the attic will be resolved by January 5, 2024. The opening at each of the two shafts will be closed by adding concrete blocks to opening. The Maintenance worker will have both shafts secured by that date.	01/05/2024

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	Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 1:45 p.m. to 3:30 p.m. on 12/13/23, two vertical shafts extending from the basement storage room to the attic were noted in the basement storage room. The shafts were constructed of concrete blocks but had openings in the shafts where shaft access doors had been in place, for penetrations of the shaft walls and at the top of each of the shafts. The shafts were open to the attic and were not separated from the attic as the opening into the attic was observed from the basement with a flashlight. Based on interview at the time of the observations, the Administrator stated the two shafts were for former dumbwaiter locations which had been taken out of the facility a long time ago, the dumbwaiter access doors had also been removed and agreed the aforementioned shafts were not enclosed by a minimum one-hour fire-rated construction. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b)			
K 0321 SS=F Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4.			

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	Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	1. Based on observation and interview, the facility failed to ensure 1 of over 8 hazardous areas such as combustible storage rooms/spaces (over 50 square feet) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 1:45 p.m. to 3:30 p.m. on 12/13/23, two vertical shafts extending from the basement storage room to the attic were noted in the basement storage room. The shafts were	K 0321	The deficient practice of not having open shafts in the basement not being separated from the attic will be resolved by January 5, 2024. The opening at each of the two shafts will be closed by adding concrete blocks to opening. The Maintenance worker will have both shafts secured by that date. The deficient practice of having the laundry doors propped open with a wedge was resolved on 12/14/2023. The Administrator removed the wedges from the laundry and placed them in his office. The laundry staff was then educated on why they cannot prop	01/05/2024

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	constructed of concrete blocks but had openings in the shafts where shaft access doors had been in place, for penetrations of the shaft walls and at the top of each of the shafts. The shafts were open to the attic and were not separated from the attic as the opening into the attic was observed from the basement with a flashlight. The basement storage room was larger than 50 square feet in size and was used for shelf storage of combustible boxes and supplies. Based on interview at the time of the observations, the Administrator stated the two shafts were for former dumbwaiter locations which had been taken out of the facility a long time ago, the dumbwaiter access doors also had been removed and agreed the aforementioned basement storage hazardous area was not separated from other spaces with smoke resistant partitions and doors. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of over 8 hazardous areas such as Laundries (larger than 100 square feet) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff, and visitors in the vicinity of the Laundry Room. Findings include: Based on observations with the Administrator during the initial walk through of the facility from 10:05 a.m. to 10:30 a.m. on 12/13/23, a wedge was		the doors open with anything. The Administrator and/or his designee will check on the laundry doors every day during their walk through the building.	

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	placed on the floor under the corridor door to the Laundry Room in the service hall to prop the door in the fully open position. Based on observations with the Administrator and the Maintenance Director at 3:15 p.m. on 12/13/23, the wedge was still in place on the floor under the corridor door to the Laundry Room to prop the door in the fully open position. Based on interview at the time of the observations, the Administrator agreed the aforementioned hazardous area was not separated from other spaces with smoke resistant partitions and doors. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b)			
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.			

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	19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction for 1 of 2 ceilings in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect over 20 residents, staff and visitors in the main dining room. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 1:45 p.m. to 3:30 p.m. on 12/13/23, the ceiling mounted sprinkler location above the sink area in the main dining room was missing its escutcheon. Based on interview at the time of the observations, the Administrator and the Maintenance Director agreed the aforementioned ceiling mounted sprinkler location was missing its escutcheon. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b)	K 0351	The deficient practice of the missing escutcheon ring above the sink area in the main dining room will be resolved by January 13, 2024. Ryan Fire Protection was in the facility on December 28, 2023 and they determined that adding an escutcheon ring was not the proper fix for the situation. They have ordered a new drop down pendant that will have to be installed once it comes in and then an escutcheon ring will be added at that time. Ryan Fire Protection states that the new pendants have been taking 10 to 14 days to get in, so they are hopeful that they will have in and have it installed by the January 13, 2024 date. But they added that sometimes it takes longer to get those in but they assured the Administrator that once it was in they would be in the facility to install it. I have attached a copy of an email from Ryan Fire Protection, page 32, that shows that the pendant has been ordered and when it comes in it will be instilled and the escutcheon added.	01/13/2024
K 0355 SS=D Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for			

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	Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 1. Based on observation and interview, the facility failed to ensure 1 of 17 portable fire extinguishers had pressure gauge readings in the acceptable range in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.2 requires periodic inspection of fire extinguishers shall include pressure gauge reading or indicator in the operable range or position. When an inspection of any rechargeable dry chemical fire extinguisher reveals a deficiency in Section 7.2.2(3) or 7.2.2(4), the extinguisher shall be subjected to applicable maintenance procedures. This deficient practice could affect over 2 staff and visitors in the basement. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 1:45 p.m. to 3:30 p.m. on 12/13/23, the pressure gauge on the freestanding portable ABC type fire extinguisher in the basement on the work bench showed the extinguisher was undercharged. The portable fire extinguisher inspection contractor had an affixed maintenance tag indicating the annual maintenance for the fire extinguisher was performed in August 2023. The affixed maintenance tag also indicated monthly inspections by facility staff had been documented through November of 2023. Based on interview at the time of the observations, the Maintenance Director agreed the pressure gauge on the portable fire extinguisher in the basement indicated the fire extinguisher was undercharged. These findings were reviewed with the Administrator during the exit conference.	K 0355	The deficient practice of an extinguisher being undercharged and not being hung on the wall has been resolved on 12/28/2023. Ryan Fire Protection came out on 12/28/2023 with a new extinguisher and a wall hanger and resolved the issues that we had with that one extinguisher in the basement. The Maintenance worker and/or his designee will check the fire extinguishers monthly to make sure that they are fully charged and hanging on the wall. Addendum: Attached is the form that will be used to make sure that this is checked monthly. You can find the form on page 29 of the packet that I have attached.	12/28/2023

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3.1-19(b)

2. Based on observation and interview, the facility failed to ensure 1 of 17 portable fire extinguishers in the facility were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means:
(1) Securely on a hanger intended for the extinguishers.
(2) In the bracket supplied by the extinguisher manufacture.
(3) In a listed bracket approved for such purpose.
(4) In a cabinet or wall recess.
Section 6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 pounds shall be installed so that the top of the fire extinguisher is not more than 5 feet above the floor. This deficient practice could affect over 2 staff and visitors in the basement.

Findings include:

Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 1:45 p.m. to 3:30 p.m. on 12/13/23, the ABC portable fire extinguisher located in the basement on the work bench was freestanding on the work bench and was not secured. The portable fire extinguisher was not secured in its wall mounted bracket just above the work bench. The portable fire extinguisher inspection contractor had an affixed maintenance tag indicating the annual maintenance for the fire extinguisher was performed in August 2023. The affixed maintenance tag also indicated monthly inspections by facility staff had been documented

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	through November of 2023. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned portable fire extinguisher was freestanding on the work bench and not secured in its wall mounted bracket above the work bench. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors			

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	meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of over 40 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Administrator during the initial walk through of the facility from 10:05 a.m. to 10:30 a.m. on 12/13/23, a wedge was placed on the floor under the corridor door to the Activities Room to prop the door in the fully open position. Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 1:45 p.m. to 3:30 p.m. on 12/13/23, the wedge was still in place on the floor under the corridor door to the Activities Room to prop the door in the fully open position. Based on interview at the time of the observations, the Administrator agreed the aforementioned corridor door had an impediment to closing and latching into the door frame and would not resist the passage of smoke.	K 0363	The deficient practice of placing a wedge to the door of the Activity room to keep the door open will be resolved as soon as the parts come in. On December 22, 2023 the Administrator called Phoenix Security, who takes care of all the mag locks on the fire doors, to order a magnet and wiring to have the Activities Door placed on the fire system. When the fire system is triggered then the Activity Door will shut and when the fire system is not in alarm the magnet will keep the door open. The Administrator spoke with Phoenix Security on Thursday, December 28, 2023. Addendum: On December 14, 2023 the Administrator removed the wedge from the Activity Room and brought it to his office. Phoenix installed the Maglock on the Activity Door on January 3, 2024. It is now tied	01/13/2024

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	These findings were reviewed with the Administrator during the exit conference. 3.1-19(b)		into the fire system, so when the fire system alarms the activity door will close.	
K 0522 SS=D Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2			
	Based on observation and interview, the facility failed to ensure 1 of 1 basements was 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 physical problems for all staff in the basement. This deficient practice could affect over two staff and visitors in the basement. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 1:45 p.m. to 3:30 p.m. on 12/13/23, it could not be determined if the natural gas fired furnaces in the basement were continually provided with combustion air supply taken directly from the outside when in operation. Each	K 0522	The deficient practice of not providing intake combustion air from the outside for the room containing fuel fired equipment will be taken care of by BJ Heating and Cooling. The Administrator spoke with Barry, owner of BJ Heating and Cooling, on Friday, December 22, 2023. Barry had come in earlier in the week to look the situation over. On Friday the Administrator told Barry to go ahead with plan of getting outside air to the furnace equipment in the basement in order to meet the codes correctly. BJ Heating and Cooling completed the work on December 29, 2023.	12/29/2023

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	furnace had a PVC fixture and related piping routed to the outside of the facility attached to the furnace but each furnace did not have piping for make up air from the outside. No other source of make up air for the furnaces in the room were noted. Based on interview at the time of the observations, the Administrator and the Maintenance Director stated the affixed PVC piping for each furnace was the exhaust for each furnace, the make up air for the furnaces is the return air of the forced air systems and agreed it could not be determined if the natural gas fired furnaces in the basement were continually provided with combustion air supply taken directly from the outside when in operation. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b)			
K 0712 SS=C 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 expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7			
	Based on record review and interview, the facility failed to conduct quarterly fire drills under varying conditions on the third shift for 3 of 4 quarters. This deficient practice could affect all residents,	K 0712	The deficient practice of not having fire drills on third shift at unexpected times has been taken care of on 12/14/2023. The	12/14/2023

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	staff and visitors in the facility. Findings include: Based on review of "Fire Drill Log" documentation with the Administrator and the Maintenance Director during record review from 10:45 a.m. to 1:45 p.m. on 12/13/23, three of four third first shift fire drills conducted within the most recent twelve month period on 05/17/23, 08/23/23 and 11/01/23 were conducted at, respectively, 2:30 a.m., 2:30 a.m. and 1:40 a.m. Based on interview at the time of record review, the Administrator stated the facility operates three shifts per day and agreed the aforementioned third shift fire drills were not conducted at unexpected times under varying conditions. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b) and 3.1-51(c)		Administrator and/or his designee will monitor the fire drills and make sure that they are being performed at unexpected times under varying conditions.	
K 0914 SS=D Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing 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			

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	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. 6.3.4 (NFPA 99)			
	Based on record review, observation and interview; the facility failed to ensure nonhospital-grade electrical receptacles that failed annual testing in 1 of over 20 resident rooms were replaced with hospital-grade receptacles. NFPA 70, The National Electrical Code, 2011 Edition, at Article 517.18(B) states each patient bed location shall be provided with a minimum of four receptacles. They shall be permitted to be of the single, duplex, or quadruplex type, or any combination of the three. All receptacles, whether four or more, shall be listed "hospital grade" and so identified. It is not intended that there be a total, immediate replacement of existing non-hospital grade receptacles. It is intended, however, that non-hospital grade receptacles be replaced with hospital grade receptacles upon modification of use, renovation, or as existing receptacles need replacement. This deficient practice could affect 2 residents and staff in Room 200. Findings include: Based on review of "Receptacle Tests (Patient Care Areas)-Facility" documentation dated 10/11/23 with the Administrator and the Maintenance Director during record review from 10:45 a.m. to 1:45 p.m. on 12/13/23, an electrical	K 0914	The deficient practice of not having a hospital grade electrical receptacles has been resolved. The Maintenance worker replaced the electrical receptacles in resident room 200. All the receptacles in room 200 are now hospital grade receptacles. The Maintenance Department and/or his designee will continue to check the receptacles and the failed receptacles will be replaced with hospital grade receptacles.	12/26/2023

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	receptacle in resident sleeping Room 200 was replaced following annual receptacle testing. The 10/11/23 annual inspection and testing documentation indicated the electrical receptacle identified as "Device 1" was "replaced" because it failed "Ground Retention" force testing. Based on interview at the time of record review, the Maintenance Director stated he believed he replaced the receptacle which failed annual testing with a hospital grade receptacle but was not certain if the replacement was hospital grade. Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 1:45 p.m. to 3:30 p.m. on 12/13/23, the electrical receptacle location identified by the Maintenance Director as "Device 1" in resident sleeping Room 200 was not hospital-grade. Based on interview at the time of the observations, the Maintenance Director agreed the receptacle location identified as "Device 1" was not hospital-grade. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b)			
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 safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with			

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	NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1. Based on record review, observation, and interview; the facility failed to ensure a written record of weekly inspections for the facility's emergency generator was maintained for 5 weeks of the most recent 52 week period. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available	K 0918	The deficient practice of not doing the weekly generator inspection documentation has been corrected on 12/27/2023. The Maintenance worker trained the Administrator on what to check and how to document what is checked. Going forward the Maintenance worker will make sure that the generator will be inspected and documented each week. In the event that he is off during a week the Administrator will do the inspection and documentation. The deficient practice of not	12/27/2023

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	for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of "Maintenance Log-Emergency Generator" documentation with the Administrator and the Maintenance Director during record review from 10:45 a.m. to 1:45 p.m. on 12/13/23, weekly emergency generator inspection documentation for one week in March, April and August 2023 and a two week period in September 2023 was not available for review. Based on interview at the time of record review, the Maintenance Director stated the facility has one natural gas fired emergency generator and stated he performs visual inspections on a weekly basis but agreed weekly inspection documentation for the five week period was not available for review. Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 1:45 p.m. to 3:30 p.m. on 12/13/23, the natural gas fired emergency generator for the facility located outside the building had an affixed nameplate indicating the generator was rated at 35 kW. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 remote manual stops for the facility's emergency generator was labeled in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 15.5.1.3 states emergency generators and standby power system, where required for compliance with this		running the generator for 4 hours at least every 36 months has been resolved on 12/27/2023. The Maintenance worker and/or his designee will make sure that this test is done at least every 36 months. Attached pages 1-26. The deficient practice of not having the remote manual stop button labeled was resolved on December 27, 2023. The Maintenance worker installed a plastic cover over the button and labeled it as "remote manual stop station". The Maintenance Department and/or his designee will check during the morning rounds to make sure the remote manual stop station remains labeled.	

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	code, shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 2010 edition, 5.6.5.6 states all installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. The remote manual stop station shall be labeled. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 1:45 p.m. to 3:30 p.m. on 12/13/23, the natural gas fired emergency generator for the facility located outside the building had an affixed nameplate indicating the generator was rated at 35 kW. A remote emergency stop button was located on the exterior of the building remote from the weatherproof shell for the emergency generator, but the remote emergency stop button was not labeled. Based on interview at the time of the observations, the Administrator agreed the remote manual stop station was not labeled. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b) 3. Based on record review, observation, and interview; the facility failed to document 36 month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type			

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	1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Administrator and the Maintenance Director from 10:45 a.m. to 1:45 p.m. on 12/13/23, thirty-six month period emergency generator testing documentation for four continuous hours for the facility's natural gas fired emergency generator was not available for review. Based on interview at the time of record review, the Administrator stated the facility has one natural gas fired emergency generator and agreed documentation of supplemental load testing for four hours within the most recent three year period was not available for review. Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 1:45 p.m. to 3:30 p.m. on 12/13/23, the natural gas fired emergency generator for the facility located outside the building had an affixed nameplate indicating the generator was rated at 35 kW.			

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	These findings were reviewed with the Administrator during the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5			
	Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with	K 0920	The deficient practice of having a refrigerator and a microwave oven plugged into a power strip in the nurse's station in the Covid Red Zone was resolved on December 13, 2023. The Administrator and	12/13/2023

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	NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the nurse's station for Covid in the 300 wing. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 1:45 p.m. to 3:30 p.m. on 12/13/23, a refrigerator and a microwave oven were plugged into a power strip in the nurse's station for Covid in the 300 Hall. Based on interview at the time of the observations, the Administrator agreed a power strip was being used as a substitute for fixed wiring at the aforementioned location. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b)		Maintenance worker went to the nurse's station after Life Safety left the facility and removed the power strip from the nurse's station and plugged the refrigerator and the microwave oven into an electrical receptacle in the wall. The Administrator and/or his designee will check the nurse's station out during the morning rounds.	