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
	155674	A. BUILDING -- B. WING	03/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ST CHARLES HEALTH CAMPUS	3150 ST CHARLES ST JASPER, IN 47546

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/15/23 Facility Number: 002628 Provider Number: 155674 AIM Number: 200299110 At this Emergency Preparedness survey, St. Charles Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 68 certified beds. At the time of the survey, the census was 53. Quality Reveiw completed on 03/23/23	E 0000	The submission of this plan of correction does not indicate an admission by St. Charles Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of St. Charles Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).	K 0000	The submission of this plan of correction does not indicate an admission by St. Charles Health Campus that the findings and allegations contained herein are	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jon Howard	Executive Director	04/12/2023

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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	Survey Date: 03/15/23 Facility Number: 002628 Provider Number: 155674 AIM Number: 200299110 At this Life Safety Code survey, St. Charles Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 68 and had a census of 53 at the time of this survey. All areas where the residents have customary access were sprinklered, and all areas providing facility services were sprinklered, except a small detached plastic storage shed. Quality Reveiw completed on 03/23/23		accurate, true representation of the quality of care provided, and living environment provided to the residents of St. Charles Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.			

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	18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 2 of 6 exit means of egress were continuously maintained free of obstructions. This deficient practice could affect at least 10 residents, as well as staff and visitors. Findings include: Based on observations on 03/15/23 between 11:50 a.m. and 1:15 p.m. during a tour of the facility with the Director of Plant Operations, there was a large golf cart, grill, and several other storage items stored under a metal roof canopy which was part of the path to the public way from the 300 hall and Service hall exit discharges. Based on interview at the time of observation, the Director of Plant Operations acknowledged the items stored under the metal roof canopy and said he would have them moved to make sure there was a clear path to the public way from the 300 hall and Service hall exit discharges. This finding was reviewed with the Executive Director and Director of Plant Operations during the exit conference. 3.1-19(b)	K 0211	**K-211 – Means of Egress** Compliance Date – 4-14 23 **Immediate Intervention** The Director of Plant Operations removed equipment and other items from rear of campus to allow for proper egress. The Director of Plant Operations was educated by the Executive Director on K211 – Means of Egress – General. Aisles, passageways, corridor's, exit discharges, exit locations, and access are in accordance with Chapter 7 The Director of Plant Operations will audit the rear exit for campus for obstructions impeding the path of egress 1 X per week X 6 weeks. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect staff or residents using the exit.	04/14/2023
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit			

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	discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to maintain the walking surface for 1 of 6 exit discharge areas from the skilled care unit. This deficient practice could affect at least 10 residents, as well as staff and visitors. Findings include: Based on observations on 03/15/23 between 11:45 a.m. and 1:15 p.m. during a tour of the facility with the Director of Plant Operations, the space where the concrete stoop and the connecting sidewalk meet outside the 100 hall exit had a three foot long, one to two inch crack. The crack in the sections of the sidewalk to the public way could be a tripping hazard while exiting from this area in the event of an emergency. Based on interview at the time of each observation, the Director of Plant Operations agreed there was a three foot long, one to two inch crack in the section of the concrete sidewalk to the public way. This finding was reviewed with the Executive Director and Director of Plant Operations during the exit conference. 3.1-19(b)	K 0271	**K271 – Discharge from Exits** Compliance Date 4/14/23 **Immediate Intervention** The Director of Plant Operations as patched to level the sidewalk area outside 100 hall. The Director of Plant Operations was educated by the Executive Director on NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. 18.2.7, 19.2.7, S&C 05-38 The Director of Plant Operations will audit discharge exits 1 x per week x three month followed by 1 x per month. The results of these inspections will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect 10 resident as well as other staff/residents	04/14/2023

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K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1			
	Based on observation and interview, the facility failed to ensure 1 of 2 battery powered emergency light sets were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on observations on 03/15/23 between 11:50 a.m. and 1:15 p.m. during a tour of the facility with the Director of Plant Operations, the battery backup light set located at the generator did not illuminate when tested several times. Based on interview at the time of observation, the Director of Plant Operations said the light worked properly the last time it was tested, but acknowledged the battery backup light set did not work when tested several times. This finding was reviewed with the Executive Director and Director of Plant Operations during the exit conference.	K 0291	**K291- Emergency lighting** Compliance Date 4/14/23 Immediate Intervention The Director of plant operations replaced the bulb for the battery back-up light. The DPO was educated by the Executive Director on NFPA 101 Emergency Lighting. Functional testing shall be conducted annually for a minimum of 1 ½ hours if the emergency lighting system is battery powered. The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). Written records of visual inspections and tests shall be kept for inspection by the AHJ. The Director of Plant Operations will inspect the facility 1 x per month x 3 months for the deficient emergency lighting. Results of these inspections will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved The deficient practice could affect	04/14/2023

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	3.1-19(b)		all residents, staff and visitors.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor doors to 1 of over 10 hazardous area doors, such as a Medical Records	K 0321	**K321** **Completion Date 4-14-23** **Hazardous Areas - Enclosure**	04/14/2023

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	room door, was provided with a self closing device. This deficient practice could affect at least 10 residents, staff, and visitors while in the same smoke compartment as the Medical Records room. Findings include: Based on observations on 03/15/23 between 11:50 a.m. and 1:15 p.m. during a tour of the facility with the Director of Plant Operations, the Medical Records room was over 50 square feet in size, and had one wall with shelves full of combustible items such as cardboard boxes. The corridor door to this room was not provided with a self closing device to ensure the door would close automatically. Based on interview at the time of observation, the Director of Plant Operations said the Medical Records room was being used to store COVID test kits which is what was in the cardboard boxes, and agreed the door to this hazardous area room did not self close automatically when tested. This finding was reviewed with the Executive Director and Director of Plant Operations during the exit conference. 3.1-19(b)		**Immediate intervention** Installed approved door closer for the MDS office and verified its operation. The director of plant operations was educated by regional support on NFPA 101- hazardous areas as regards to the corridor door to this room requiring a self-closing device in accordance to 8.7.1 or 19.3.5.9, 19.3.2.1 The director of plant operations will visually inspect all doors that exit into the common corridor weekly x 3 months then monthly x3. The Executive Director will present the results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved. This had the potential to affect staff and residents on this hall	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code.			

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	Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure 37 of 157 smoke detectors that failed the sensitivity test was replaced or repaired. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the	K 0345	**K-0345** Completion Date 4-14-23 Immediate action Director of plant operations notified alarm company who sent out employees to replace smoke detectors that did not pass inspection. Executive Director educated director of plant operations on NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 and the testing of smoke detectors. The director of plant operations will monitor Alarm company's reports and repair/replace any noted concerns on report timely. The Executive Director will present the results of inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved. This had the potential to affect staff and residents	04/14/2023

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	detector. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 03/15/23 between 9:30 a.m. and 11:50 a.m. with the Director of Plant Operations present, the smoke detector sensitivity test report dated 11/17/22 indicated 37 of 157 smoke detectors had failed. There was no documentation available to show that the failed smoke detectors had been replaced or repaired. Based on interview at the time of record review, the Director of Plant Operations confirmed that there was no documentation available to show that the 37 smoke detectors had been replaced or repaired since the 11/17/22 sensitivity test report. This finding was reviewed with the Executive Director and Director of Plant Operations during the exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source			

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	Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 1 of 1 fire department connections were in accordance with NFPA 25, 2011 Edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 13.7.1 requires fire department connections to be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. This deficient practice could affect all occupants. Findings include: Based on observations on 03/15/23 between 11:50 a.m. and 1:15 p.m. during a tour of the facility with the Director of Plant Operations, the facility's fire department connections (FDC) was located on the back side of the facility. There was no FDC signage provided around the fire department connection or at the front of the building for the responding fire department to lead them to the FDC for easy identification. Based on interview at the time of observation, this was acknowledged by the Director of Plant Operations who agreed	K 0353	**K 0353** **Completion Date 4-14-23** **Immediate action** **Director of plant operation installed signs at front and back of campus to alert Fire department of FDC location** **Executive director educated director on NFPA 25 standard for the inspection, testing, and maintenance of water-based fire protection system.** **Director of plant operations will monitor signage 1x per month x 3 months for proper signage.** **Results of these inspections will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved** **The deficient practice could affect all residents, staff and visitors.**	04/14/2023

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	there should be FDC signage at the FDC and the front of the facility. This finding was reviewed with the Executive Director and Director of Plant Operations during the exit conference. 3.1-19(b)			
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review and interview, the facility failed to ensure 52 of over 200 fire dampers in the facility were inspected and provided necessary maintenance at least every four years (in non-health care occupancies) and six years (in health care occupancies) in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any	K 0521	**K 0521** **Completion Date 4-14-23** **Immediate action** Director of plant operation and other maintenance personnel will inspect campus HVAC dampers needing inspected. **Executive director educated director on** NFPA 90A, 2012 Edition, Section 5.4.8.1 stating fire dampers shall be maintained. **Director of plant operations will monitor dampers per NFPA guidelines for effectiveness.** **Results of these inspections will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality**	04/14/2023

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	way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents and all other occupants in the facility. Findings include: Based on record review on 03/15/23 between 9:30 a.m. and 11:50 a.m. with the Director of Plant Operations present, there was an in house created fire damper maintenance record dated 02/18/19 available for review, however, only 52 of over 200 fire dampers were inspected/tested during that inspection/test. Furthermore, the fire dampers are almost a month past due for inspection/testing. This was acknowledged by the Director of Plant Operations at the time of record review. This finding was reviewed with the Executive Director and Director of Plant Operations during the exit conference. 3.1-19(b)		**Assurance Team determines substantial compliance has been achievedThe deficient practice could affect all residents, staff and visitors.**	
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			

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	155674	A. BUILDING 01 B. WING	03/15/2023

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	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 ensure fire drills were held at varied times for 2 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 03/15/23 between 9:30 a.m. and 11:50 a.m. with the Director of Plant Operations present, the following was noted: a. Three of four, second shift (evening) fire drills were performed between 2:10 p.m. and 2:26 p.m. b. Three of four, third shift (night) fire drills were performed between 10:30 p.m. and 11:00 p.m. Based on interview at the time of record review, the Director of Plant Operations acknowledged the times the second and third shift fire drills were performed and agreed the times were not varied enough. This finding was reviewed with the Executive Director and Director of Plant Operations during the exit conference. 3.1-19(b)	K 0712	**K 0712** **Completion Date 4-14-23** **Immediate action** **Director of plant operation initiated Fire drills on each shift with varied times** **Executive director educated director on varying fire drill times** **ED/designee will monitor fire drill times monthly x 3 months for proper varied times.** **Results of these inspections will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achievedThe deficient practice could affect all residents, staff and visitors.**	04/14/2023
K 0761 SS=C Bldg. 01				
	Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 1 of 1 oxygen room fire door assembly and 1 of 1 set of separation fire doors assembly between the Assisted Living Unit	K 0761	**K 0761** **Completion Date 4-14-23** **Immediate action**	04/14/2023

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	and Skilled Care Unit were completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.		**Director of plant operation inspected/tested all fire doors for proper use along with proper documentation. Executive director educated director on** NFPA 80 5.2.1 **Director of plant operations will inspect/test doors per NFPA regulation** **Results of these inspections will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achievedThe deficient practice could affect all residents, staff and visitors.**	

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	(7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, as well as staff, and visitors. Findings include: Based on record review on 03/15/23 between 9:30 a.m. and 11:50 a.m. with the Director of Plant Operations present, the facility was able to provide documentation for an annual inspection of the oxygen transfilling room fire door assembly and the set of separation fire doors assembly between the Assisted Living Unit and the Skilled Care Unit, however, the inspection documentation provided was dated 02/10/22, which was a month past due for their annual inspection/testing. Based on interview at the time of record review, the Director of Plant Operations said the documentation provided was the most recent annual inspection of the oxygen transfilling room fire door assembly and the set of separation fire doors assembly. Based on observations during a tour of the facility with the Director of Plant Operations between 11:50 a.m. and 1:15 p.m., it was confirmed there was one oxygen transfilling room fire door assembly and one set of separation fire doors assembly noted in the facility. This finding was reviewed with the Executive Director and Director of Plant Operations during			

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	the exit conference. 3.1-19(b)			
K 0916 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator annunciator panel was in proper operating condition. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on observations on 03/15/23 at 12:40 p.m. during a tour of the facility with the Director of Plant Operations, the generator annunciator panel located at the Nurses' Station had no power. There was a piece of tape over the screw-in fuse. The Director of Plant Operations took the tape off and screwed the fuse back into the panel and it worked properly. Based on interview at the time of observation, the Director of Plant Operations said the panel has an audible alarm that sounds when the generator is exercised and must have been turned off by staff during its last run time.	K 0916	**K 0916** **Completion Date 4-14-23** **Immediate intervention** Director of plant operations installed fuse into panel for proper operation. The director of plant operations was educated by Executive Director on maintaining a operational generator annunciator panel. The director of plant operations will visually inspect Generator annunciator panel weekly x 3 months then monthly x3. The Executive Director will present the results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	04/14/2023

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	This finding was reviewed with the Executive Director and Director of Plant Operations during the exit conference. 3.1-19(b)		This had the potential to affect staff and residents	