STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155716	A. BUILDING -- B. WING	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

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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 Dates: 12/11/23 Facility Number: 000439 Provider Number: 155716 AIM Number: 100275070 At this Emergency Preparedness survey, Envive of Evansville was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 212 certified beds and had a census of 116 at the time of this survey. Quality Review completed on 12/12/23 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Life Safety and Emergency Preparedness Survey conducted December 11, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of January 1, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2),			

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

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	§418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.			

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	*[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.			
	Based on record review and interview, the facility failed to maintain a complete emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants. Findings include:	E 0006	**E006** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** A facility-based and community-based risk assessment utilizing an all-hazards approach was completed and addressed emergency events as identified by the risk assessment.	01/01/2024

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	Based on review of the emergency preparedness plan on 12/11/23 between 9:00 a.m. and 3:15 p.m. with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator present, facility-based and community-based risk hazards were addressed in the plan, and there was a facility-based and community-based risk assessment utilizing an all-hazards approach available for review, however, the all-hazards approach risk assessment only included natural disasters that could happen in the area of the facility. The risk assessment did not include a list of man created risks. Based on interview at the time of record review, the Executive Director agreed the facility-based and community-based risk assessment utilizing an all-hazards approach did not include a full list of potential hazards. This finding was reviewed with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator during the exit conference.		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected. A facility-based and community-based risk assessment utilizing an all-hazards approach was completed and addressed emergency events as identified by the risk assessment. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** A form which addresses both facility-based and community-based risk utilizing and all-hazards approach was reviewed by the IDT and determined to be appropriate. Individuals on the QAPI committee were educated on the rules regarding the assessment. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The facility-based and community-based risk assessment utilizing an all-hazards approach which	

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			addresses emergency events as identified by the risk assessment will be reviewed annually in the QAPI meeting on an ongoing basis. **By what date the systemic changes for each deficiency will be completed: January 1, 2024**	
E 0026 SS=C Bldg. --	403.748(b)(8), 416.54(b)(6), 418.113(b)(6)(C)(iv), 441.184(b)(8), 482.15(b)(8), 483.475(b)(8), 483.73(b)(8), 485.625(b)(8), 485.920(b)(7), 494.62(b)(7) Roles Under a Waiver Declared by Secretary §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.			

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	*[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.73(b)(8). This deficient practice could affect all occupants. Findings include: Based on review of the emergency preparedness plan on 12/11/23 between 9:00 a.m. and 3:15 p.m. with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator present, the plan did not address the role of the LTC facility under a waiver declared by the Secretary. Based on interview at the time of record review, the Executive Director acknowledged the available plan did not address the role of the LTC facility under a waiver declared by the Secretary. This finding was reviewed with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator during the exit conference.	E 0026	**E026** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** The facility has included a policy for operating under an 1135 waiver in the Emergency Preaparedness Plan. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected. The facility has included a policy for operating under an 1135 waiver in the Emergency Preaparedness Plan. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The IDT reviewed the policy for the 1135 waiver and determined it to be appropriate. The facility has included a policy for operating under an 1135 waiver in the Emergency Preparedness Plan. Staff was educated on the 1135 waiver.	01/01/2024

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			How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Emergency Preparedness plan including the 1135 waiver will be reviewed by the IDT annually during the QAPI Meeting. **By what date the systemic changes for each deficiency will be completed: January 1, 2024**	
E 0041 SS=E 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 Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety			

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	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: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.			

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	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 and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2).	E 0041	**E041** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:**	01/01/2024

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	1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 3 generators was maintained for 18 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect up to 25 residents, staff and visitors in the Pavilion unit. Findings include: Based on review of the generator inspection and testing reports on 12/11/23 between 9:00 a.m. and 3:15 p.m. with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator present, there was no documentation available to show the emergency generator for the Pavilion unit was inspected/tested weekly between July 26 and December 7, 2023. Based on interview at the time of record review, the Director of Maintenance confirmed there was a lack of inspection/testing documentation for the Pavilion unit during the previously mentioned time frame, and also said the generator timer was not working correctly during that time frame and the generator maintenance vendor had been to the facility		The weekly generator inspection and monthly load test was done, and a written documentation was completed for the one generator affected. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** If there were a power outage, residents on a unit requiring generator power could be affected. All generators have been inspected and written documentation completed for both the weekly inspections and the monthly load test. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Staff were educated in how to manually initiate a check and complete the documentation correctly. The facility has initiated the TELs system which tracks required Life Safety inspections and prompts the completion of required inspections and documentation including the weekly inspections and monthly load testing. Maintenance staff were educated in the use of TELs. **How the corrective action will**	

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	several times to try and identify the problem. The Director of Maintenance further said the generator does start automatically with the loss of power and when testing the generator manually. This finding was reviewed with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator during the exit conference. 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 3 generators during 4 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect up to 25 residents, staff and		**be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit report will be pulled from the TELs system and reviewed weekly by the administrator or designee to monitor the completion of the required testing. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed: January 1, 2024**	

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	visitors in the Pavilion unit. Findings include: Based on review of the generator inspection and testing reports on 12/11/23 between 9:00 a.m. and 3:15 p.m. with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator present, there was no monthly generator load test documentation available for 4 of the past 12 months (August, September, October, and November of 2023) for the Pavilion unit emergency generator. Based on interview at the time of record review, the Director of Maintenance confirmed there was no emergency generator load test documentation for August, September, October, and November of 2023 for the Pavilion unit emergency generator, and also said the generator timer was not working correctly during that time frame and the generator maintenance vendor had been to the facility several times to try and identify the problem. The Director of Maintenance further said the generator does start automatically with the loss of power and when testing the generator manually. This finding was reviewed with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator 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 Dates: 12/11/23	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The	

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(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
	Facility Number: 000439 Provider Number: 155716 AIM Number: 100275070 At this Life Safety Code survey, Envive of Evansville 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 two separate basements was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, both basements, and all resident sleeping rooms. The facility has a capacity of 212 certified beds and had a census of 116 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except two detached wood sheds used for facility storage and one plastic shed used for bio hazard waste. Quality Review completed on 12/12/23		Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Life Safety and Emergency Preparedness Survey conducted December 11, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of January 1, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0291 SS=C 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 record review, observation, and	K 0291	**K291**	01/01/2024

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	interview; the facility failed to ensure there was documentation for the testing of 32 of 32 battery backup lights that were tested monthly for 30 seconds during 2 of the past 12 months to ensure the lights would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review on 12/11/23 between 9:00 a.m. and 3:15 p.m. with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator present, the facility did have a preventative maintenance (PM) report that battery powered emergency lights were tested monthly, however, there was no 30 second monthly testing documentation since 09/13/23. Based on an interview at the time of record review, the Regional Maintenance Coordinator agreed the PM form for the battery powered emergency lights did not include 30 second monthly testing for each battery powered light since 09/13/23. During a tour of the facility with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator on 12/11/23 between 3:15 p.m. and 6:00 p.m., the facility was equipped		**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Unable to complete missed testing. Testing was completed on the 32 emergency-back-up lighting with documentation completed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Residents present during a power outage would have the potential to be affected. The testing was completed on the 32 emergency-back-up lighting with documentation completed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The maintenance staff was educated on the requirements for testing of the emergency lighting, how to complete it, and the documentation that goes along with it. The facility has initiated the use of the TELs system which tracks and gives reminders for the required Life Safety inspection including emergency-back-up lighting. Maintenance staff have been educated in the use of the	

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	with many emergency battery powered lights. This finding was reviewed with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator during the exit conference. 3.1-19(b)		TELs system and how to add required documentation. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit report will be pulled from the TELs system and reviewed weekly by the administrator or designee to monitor the completion of the required testing. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed: January 1, 2024**	
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.			

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	a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters for 5 of 5 sprinkler systems. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility.	K 0353	**K353** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Unable to complete missed inspections. 1 The five sprinkler systems have been inspected. 2 The two hydrants (one privately owned, and one city owned) have been inspected. 3 Sprinkler gages were calibrated/ replaced as required. 4 The monthly sprinkler gage inspections have been completed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected. 1 The five sprinkler systems have been inspected. 2 The two hydrants (one privately owned, and one city	01/01/2024

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	Findings include: Based on review of the quarterly sprinkler system inspection records on 12/11/23 between 9:00 a.m. and 3:15 p.m. with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator present, there was no quarterly sprinkler system inspection report available for the third quarter (July, August, and September) of 2023. Based on interview at the time of record review, the Director of Maintenance confirmed there was no written documentation available to show the three sprinkler systems had been inspected during the third quarter of 2023. This finding was reviewed with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 2 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2011 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Table 7.1.1.2 requires wet and dry barrel hydrants to be inspected annually and after each operation. This deficient practice affects all residents in the facility. Findings include: Based on review of the quarterly sprinkler system inspection records on 12/11/23 between 9:00 a.m. and 3:15 p.m. with the Executive Director, Director		owned) have been inspected. 3 Sprinkler gages were calibrated/ replaced as required. 4 The monthly sprinkler gage inspections have been completed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The facility has initiated the use of the TELs system which tracks and gives reminders for the required Life Safety inspections including, quarterly sprinkler inspections, annual hydrant inspections, Sprinkler gage replacement or calibration, and monthly sprinkler gage inspections. Maintenance staff have been educated in the use of the TELs system and how to add required documentation. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit report will be pulled from the TELs system and reviewed weekly by the administrator or designee to monitor the completion of the required testing. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or	

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	of Maintenance, and Regional Maintenance Coordinator present, it was determined the facility had two fire hydrants on the facility property with both fire hydrants being privately owned by the facility. The most recent documentation available for an annual inspection of the privately owned fire hydrants was dated 07/19/22, which was well over a year past due for inspection. The lack of an annual inspection for the privately owned fire hydrants was acknowledged by the Director of Maintenance at the time of record review. This finding was reviewed with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 3 of at least 10 sprinkler system gauges on 2 of 5 sprinkler system risers were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations of the facility's five sprinkler system risers on 12/11/23 between 3:15 p.m. and 6:00 p.m. with the Executive Director, Director of Maintenance, and Regional		updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after twelve months with at least four consecutive quarters of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed: January 1, 2024**	

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	Maintenance Coordinator, the following was noted: a. One of two sprinkler gauges on the Pathways unit sprinkler system riser had a date of 2015 which was over three years past due for replacement or recalibration. No recalibration date information was affixed to the dry sprinkler system gauge. b. Two of two sprinkler gauges on the dry kitchen storage room sprinkler system riser had dates of 2014 and 2015 which were over three and four years past due for replacement or recalibration. No recalibration date information was affixed to the dry sprinkler system gauge. Based on interview at the time of the observation, the Director of Maintenance confirmed the sprinkler system gauges had not been recalibrated within the most recent five year period and would have the gauges replaced as soon as possible. This finding was reviewed with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator during the exit conference. 3.1-19(b) 4. Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 3 of 5 sprinkler systems. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and the normal water pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13.			

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	Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the sprinkler system inspection records at each sprinkler riser during a tour of the facility on 12/11/23 between 3:15 p.m. and 6:00 p.m. with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator, the following was noted: a. The Pathways unit sprinkler riser had two sprinkler gauges and the monthly inspection documentation only indicated one gauge as being inspected and documented. Furthermore, there was no sprinkler gauge or control valve inspection documentation for November 2023. b. The Pavilion basement sprinkler riser had one sprinkler gauge. There was no sprinkler gauge or control valve inspection documentation for August, September, and November 2023. c. The dry kitchen storage sprinkler riser had two sprinkler gauges. There was no sprinkler gauge or control valve inspection documentation for the past 12 month period available for review. Based on interview at the time of each record review, the Director of Maintenance acknowledged the lack of sprinkler system inspections on the gauges and control valves during the past 12 months. This finding was reviewed with the Executive Director, Director of Maintenance, and Regional			

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	Maintenance Coordinator during the exit conference. 3.1-19(b)			
K 0531 SS=E Bldg. 01	NFPA 101 Elevators Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 Based on record review, observation, and interview; the facility failed to ensure documentation was provided for the testing of 1 of 1 elevator firefighter recall in accordance with 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with fire fighters' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code	K 0531	**K531** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Unable to complete missed tests. A test of the firefighter recall has been completed.	01/01/2024

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	for Elevators and Escalators. This deficient practice could affect mostly staff since residents do not use the elevator. Findings include: Based on record review on 12/11/23 between 9:00 a.m. and 3:15 p.m. with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator present, there was no documentation available for the monthly firefighter recall test for the elevator for the past 12 months and prior. Based on interview at the time of record review, the Director of Maintenance said there was no documentation available for the testing of the firefighter recall for the elevator. Based on observation on 12/11/23 between 3:15 p.m. and 6:00 p.m. during a tour of the facility with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator the elevator was equipped with a firefighter recall key operation at the main floor level. This was confirmed by the Executive Director at the time of observation. This finding was reviewed with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator during the exit conference. 3.1-19(b)		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** No residents have the potential to be affected as it is not a resident use elevator. A test of the firefighter recall has been completed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The facility has initiated the use of the TELs system which tracks and gives reminders for the required Life Safety inspections including monthly testing of the firefighter recall. Maintenance staff have been educated in the use of the TELs system and how to add required documentation. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit report will be pulled from the TELs system and reviewed weekly by the administrator or designee to monitor the completion of the required testing. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as	

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			needed to achieve, and maintain compliance. Audits may be discontinued after 12 months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed: January 1, 2024**	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at 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 1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 1 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's fire drill reports on 12/11/23 between 9:00 a.m. and 3:15 p.m. with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator present,, the facility lacked fire drill documentation for the second shift (evening) of the fourth quarter (October, November, and December) of 2022.	K 0712	**K712** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Unable to complete a missed drill or documentation. A fire drill was completed for all three shifts this quarter and documentation was complete. **How other residents having the potential to be affected by the same deficient practice will be**	01/01/2024

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	Based on interview at the time of record review, the Regional Maintenance Coordinator confirmed the lack of a fire drill report during the second shift of the fourth quarter of 2022. This finding was reviewed with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator during the exit conference. 3.1-19(b) 3.1-51(c) 2. Based on record review and interview, the facility failed to ensure 9 of 12 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 12/11/23 between 9:00 a.m. and 3:15 p.m. with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator present, 9 fire drill reports performed during the past 12 month period were not provided with documentation for the transmission of the alarm to the monitoring company. Based on interview at the time of record review, the Regional Maintenance Coordinator acknowledged there was no information on 9 of 12 fire drill reports to verify that transmission of the alarm was received by the monitoring company.		**identified and what corrective action will be taken:** All residents have the potential to be affected. A fire drill was completed for all three shifts this quarter and documentation was complete. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** A schedule was created for which shift's fire drill will be completed in each month of the quarter. The facility has initiated the use of the TELs system which tracks and gives reminders for the required Life Safety inspections including monthly fire drills (one per shift per quarter) and documentation requirements. Maintenance staff have been educated in the use of the TELs system and how to add required documentation. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit report will be pulled from the TELs system and reviewed weekly by the administrator or designee to monitor the completion of the required testing. Results of the audit will be reviewed by the QA team during	

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	This finding was reviewed with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator during the exit conference. 3-1.19(b) 3.1-51(c)		QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after twelve months with at least four quarters of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed: January 1, 2024**	
K 0914 SS=C 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 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.			

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	155716	A. BUILDING 01 B. WING	12/11/2023

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	6.3.4 (NFPA 99) Based on observation, record review, and interview; the facility failed to ensure complete documentation was available for all nonhospital-grade electrical receptacles in all resident room locations tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on record review on 12/11/23 between 9:00 a.m. and 3:15 p.m. with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator present, there was no documentation available of an annual resident room receptacle test for non hospital-grade receptacles. Based on interview at the time of record review, the Regional Maintenance Coordinator said all resident rooms throughout the facility are equipped with hospital-grade receptacles except for one Ground Fault Circuit Interrupter (GFCI) in each resident room. He further said there was no documentation to show	K 0914	**K914** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Missed assessment cannot be completed. All non-hospital grade receptacles in patient areas were tested. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected. All non-hospital grade receptacles in patient rooms were tested. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance staff were educated in the process of checking non-hospital grade receptacles. The facility has initiated the use of the TELs system which tracks and gives reminders for the required Life Safety inspections including annual testing of the receptacle. Maintenance staff have been educated in the use of the TELs system and how to add required documentation.	01/01/2024

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	that annual testing per NFPA 99, Receptacle Testing requirements was met with all pertinent information within the past 12 month period for each GFCI receptacle in each resident room. Based on observations on 12/11/23 between 3:15 p.m. and 6:00 p.m. during a tour of the facility with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator, electrical receptacles in all resident rooms were listed as hospital-grade except for one GFCI receptacle in each room. This finding was reviewed with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator during the exit conference. 3.1-19(b)		**How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit report will be pulled from the TELs system and reviewed weekly by the administrator or designee to monitor the completion of the required testing. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after twelve months with at least two consecutive years of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed: January 1, 2024**	
K 0918 SS=E 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 and interview, the facility failed to ensure a written record of weekly inspections for 1 of 3 generators was maintained for 18 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a	K 0918	**K918** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** The weekly generator inspection and monthly load test was done, and a written documentation was completed for the one generator affected. **How other residents having the potential to be affected by the same deficient practice will be**	01/01/2024

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	written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect up to 25 residents, staff and visitors in the Pavilion unit. Findings include: Based on review of the generator inspection and testing reports on 12/11/23 between 9:00 a.m. and 3:15 p.m. with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator present, there was no documentation available to show the emergency generator for the Pavilion unit was inspected/tested weekly between July 26 and December 7, 2023. Based on interview at the time of record review, the Director of Maintenance confirmed there was a lack of inspection/testing documentation for the Pavilion unit during the previously mentioned time frame, and also said the generator timer was not working correctly during that time frame and the generator maintenance vendor had been to the facility several times to try and identify the problem. The Director of Maintenance further said the generator does start automatically with the loss of power and when testing the generator manually. This finding was reviewed with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 3 generators during 4 of the past 12 months.		**identified and what corrective action will be taken:** If there were a power outage, residents on a unit requiring generator power could be affected. All generators have been inspected and written documentation completed for both the weekly inspections and the monthly load test. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Staff were educated in how to manually initiate a check and complete the documentation correctly. The facility has initiated the TELs system which tracks required Life Safety inspections and prompts the completion of required inspections and documentation including the weekly inspections and monthly load testing. Maintenance staff were educated in the use of TELs. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit report will be pulled from the TELs system and reviewed weekly by the administrator or designee to monitor the	

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	Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect up to 25 residents, staff and visitors in the Pavilion unit. Findings include: Based on review of the generator inspection and testing reports on 12/11/23 between 9:00 a.m. and 3:15 p.m. with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator present, there was no monthly generator load test documentation available for 4 of the past 12 months (August, September, October, and November of 2023) for the Pavilion unit emergency generator. Based on interview at the time of record review, the Director of		completion of the required testing. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed: January 1, 2024**	

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	Maintenance confirmed there was no emergency generator load test documentation for August, September, October, and November of 2023 for the Pavilion unit emergency generator, and also said the generator timer was not working correctly during that time frame and the generator maintenance vendor had been to the facility several times to try and identify the problem. The Director of Maintenance further said the generator does start automatically with the loss of power and when testing the generator manually. This finding was reviewed with the Executive Director, Director of Maintenance, and Regional Maintenance Coordinator during the exit conference. 3.1-19(b)			