STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155370	A. BUILDING -- B. WING	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/23/24 Facility Number: 000555 Provider Number: 155370 AIM Number: 100267530 At this Emergency Preparedness survey, Premier Healthcare of New Harmony was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 96 certified beds. At the time of the survey, the census was 46. The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by: Quality Review completed on 09/27/24	E 0000		
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.1 Develop EP Plan, Review and Update Annually Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all residents in the facility. Findings include:	E 0004	Please accept the following as the facility's credible allegation of compliance (please note that this POC is submitted per State and Federal requirements only. It should not be construed as the facility's admission of non-compliance with any State or	10/31/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jamee	O'Brien	10/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

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	Based on review of the Emergency Preparedness Plan on 09/23/24 between 9:00 a.m. and 1:00 p.m. with the Maintenance Director and Human Resources Director present, the facility did provide an emergency preparedness manual, however, it has not been reviewed and updated during the past twelve months. The most recent date of review was 02/01/23. Based on interview at the time of review, the Human Resources Director confirmed the entire Emergency Preparedness Plan has not been reviewed and updated within the past twelve month period. This finding was reviewed with the Maintenance Director, Business Office Manager, Interim Director of Nursing, Nurse Consultant, and Human Resources Director during the exit conference.		Federal standard, requirement or regulation): 1.The following corrective action(s) have been taken as follows: A The emergency preparedness manual has been reviewed and updated by the administrator and facility leadership team. See signed attendance sheet for Annual Emergency Preparedness review meeting (see exhibit E004 A). 1.All residents have the potential to be affected by this alleged deficient practice. 1.The following measures have been taken to ensure that this alleged deficient practice does not recur: A The Maintenance Supervisor and Interim Administrator have been inserviced regarding the requirement to develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. See signed inservice training sheet (exhibit E004 B). B The facility has added a yearly review of the Emergency Preparedness Manual to the Quality Assurance/Quality Improvement Committee's scheduled calendar.	

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PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

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			1.The following Quality Monitoring program has been implemented to assure that corrective actions are achieved, effective and sustained: The Administrator and/or appointed designee(s) shall monitor during the QAPI meetings if there are any issues that warrant a revision to the Emergency Preparedness Manual and will also monitor that the yearly review has been completed. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s).	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.1 Development of Communication Plan Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Plan on 09/23/24 between 9:00 a.m. and 1:00 p.m. with the Maintenance Director and Human Resources Director present, the facility's Emergency Preparedness Plan did include a plan	E 0029	Please accept the following as the facility's credible allegation of compliance (please note that this POC is submitted per State and Federal requirements only. It should not be construed as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation): 1.The following corrective action(s) have been taken as follows:	10/31/2024

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	to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws, however the communication plan has not been reviewed by the facility within the most recent twelve month period. The most recent date of review was 02/01/23. Based on interview at the time of review, the Human Resources Director confirmed the Communication Plan within the Emergency Preparedness Plan has not been reviewed and updated within the past twelve month period. This finding was reviewed with the Maintenance Director, Business Office Manager, Interim Director of Nursing, Nurse Consultant, and Human Resources Director during the exit conference.		A The emergency preparedness communications plan/policy has been reviewed and updated by the administrator and facility leadership team. See signed & dated review of the Emergency Preparedness Communication Plan(see Exhibit E029 A). 1.All residents have the potential to be affected by this alleged deficient practice. 1.The following measures have been taken to ensure that this alleged deficient practice does not recur: A The Maintenance Supervisor and Administrator have been inserviced regarding the requirement to develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and that this plan must be reviewed and updated at least annually. See exhibit E029 B. B The facility has added a monitoring review of the Emergency Preparedness Manual, which includes the Emergency Preparedness Communication Plan to the Quality Assurance/Quality Improvement Committee's scheduled calendar. 1.The following Quality Monitoring program has been	

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			implemented to assure that corrective actions are achieved, effective and sustained: A The Administrator and/or appointed designee(s) shall monitor during the QAPI meetings if there are any issues that warrant a revision to the Emergency Preparedness Manual and/or the Emergency Preparedness Communication Plan and will also monitor that their yearly review has been completed. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s).	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.1 EP Training and Testing Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Plan on 09/23/24 between 9:00 a.m. and 1:00 p.m. with the Maintenance Director and Human Resources Director present, there was documentation available to show the facility had an emergency preparedness training and testing program, however the training and testing	E 0036	Please accept the following as the facility's credible allegation of compliance (please note that this POC is submitted per State and Federal requirements only. It should not be construed as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation): 1.The following corrective action(s) have been taken as follows: A The emergency preparedness	10/31/2024

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	155370	A. BUILDING -- B. WING	09/23/2024

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PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

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	program has not been reviewed by the facility within the most recent twelve month period. The most recent date of review was 02/01/23. Based on interview at the time of review, the Human Resources Director confirmed the training and testing policy and procedure within the Emergency Preparedness plan has not been reviewed and updated within the past twelve month period. This finding was reviewed with the Maintenance Director, Business Office Manager, Interim Director of Nursing, Nurse Consultant, and Human Resources Director during the exit conference.		training and testing program has been reviewed and updated by the administrator and facility leadership team. See signed & dated review of the Emergency Preparedness Training & Testing Program (see Exhibit E036 A). 1.All residents have the potential to be affected by this alleged deficient practice. 1.The following measures have been taken to ensure that this alleged deficient practice does not recur: A The Maintenance Supervisor and Administrator have been inserviced regardingthe requirement to develop and maintain an emergency preparedness training and testing program that complies with Federal, State and local laws and that this plan must be reviewed and updated at least annually. See exhibit E036 B. B The facility has added a monitoring review of the Emergency Preparedness Manual, which includes the emergency preparedness training and testing program to the Quality Assurance/Quality Improvement Committee's scheduled calendar. 1.The following Quality Monitoring program has been implemented to assure that	

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			corrective actions are achieved, effective and sustained: A The Administrator and/or appointed designee(s) shall monitor during the QAPI meetings if there are any issues that warrant a revision to the emergency preparedness training and testing program and will also monitor that their yearly review has been completed. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s).	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event.	E 0039	Please accept the following as the facility's credible allegation of compliance (please note that this POC is submitted per State and Federal requirements only. It should not be construed as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation): 1.The following corrective action(s) have been taken as follows: A The facility has scheduled a Community-Based Exercise to be held October 9th and October 30,	11/14/2024

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PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

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	(ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants in the facility. Findings include: Based on review of the Emergency Preparedness Plan on 09/23/24 between 9:00 a.m. and 1:00 p.m. with the Maintenance Director and Human Resources Director present, the facility was able to provide documentation of multiple table top exercises dated 04/10/24 and 04/11/24, however, they were unable to provide documentation of a community based exercise or documentation of an emergency event during the past 12 months. Furthermore, the documentation for the five table top exercises only included the date, names of participating staff, and the subject of the exercised reviewed, plus a copy of the policy and procedure from the Emergency Preparedness Plan. Based on interview at the time of record review, the Human Resources Director said no Community Based Exercise or Emergency Event documentation was available to review during the past twelve month		2024 with CHUG (see Exhibit E039 A – confirmation of scheduled exercise). Another full-scale exercise is also scheduled for November 13, 2024. 1.All residents have the potential to be affected by this alleged deficient practice. 1.The following measures have been taken to ensure that this alleged deficient practice does not recur: A The Maintenance Supervisor and Administrator have been inserviced regarding the requirements of E039 - EP Testing Requirements. See exhibit E039 B. B The facility has contracted with the Collaborative Healthcare Urgency Group (CHUG) to assist in meeting compliance with these requirements. 1.The following Quality Monitoring program has been implemented to assure that corrective actions are achieved, effective and sustained: A The Administrator and/or appointed designee(s) shall monitor during the QAPI meetings if the facility is up-to-date on the required testing and training requirements per E039. Noted problems will be immediately	

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	period. This finding was reviewed with the Maintenance Director, Business Office Manager, Interim Director of Nursing, Nurse Consultant, and Human Resources Director during the exit conference.		corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s). Completion Date: 11/14/2024.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power 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). 1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 1 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.	E 0041	Please accept the following as the facility's credible allegation of compliance (please note that this POC is submitted per State and Federal requirements only. It should not be construed as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation): 1.The following corrective action(s) have been taken as follows: A The facility has completed, and documented in written form: a monthly generator load test. (see Exhibit E041/K918A) and a weekly generator inspection (see Exhibit E041/K918 B) 1.All residents have the potential to be affected by this alleged deficient practice. 1.The following measures have	10/31/2024

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	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 all residents, staff and visitors. Findings include: Based on review of the generator inspection and testing reports on 09/23/24 between 9:00 a.m. and 1:00 p.m. with the Maintenance Director and Human Resources Director present, there was no monthly generator load test documentation available for August, and so far in September of 2024 for the emergency generator. Based on interview at the time of record review, the Maintenance Director said he has only been in his current position as Maintenance Director since mid August of 2024 and has only performed the monthly load test one time, but only documented it in his notes as "Generator Ran for Test", with no other information provided. This finding was reviewed with the Maintenance Director, Business Office Manager, Interim Director of Nursing, Nurse Consultant, and Human Resources Director during the exit conference. 2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 1 generator was maintained for 24 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		been taken to ensure that this alleged deficient practice does not recur: A The Maintenance staff has been inserviced regarding the requirement to complete monthly generator load testing and weekly generator inspections per requirements of E041. Specific discussion was given to maintaining a written rcord of these tests and inspections. See EXHIBIT E041/K918 C 1.The following Quality Monitoring program has been implemented to assure that corrective actions are achieved, effective and sustained: A The Maintenance Supervisor and/or appointed designee(s) shall monitor that weekly generator inspections and monthly generator load tests have been completed and documented. This monitoring shall be completed monthly for a minimum of sixty (60) days and may continue longer until sustained compliance is achieved. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s). 5	

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	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 all residents, staff and visitors. Findings include: Based on review of the generator inspection and testing reports on 09/23/24 between 9:00 a.m. and 1:00 p.m. with the Maintenance Director and Human Resources Director present, there was no documentation available to show the emergency generator was inspected/tested weekly since April 10, 2024. Based on interview at the time of record review, the Maintenance Director confirmed there was no weekly inspection/testing documentation available for review. This finding was reviewed with the Maintenance Director, Business Office Manager, Interim Director of Nursing, Nurse Consultant, and Human Resources Director 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	K 0000		

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	483.90(a). Survey Date: 09/23/24 Facility Number: 000555 Provider Number: 155370 AIM Number: 100267530 At this Life Safety Code survey, Premier Healthcare of New Harmony 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 (000) 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, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 96 and had a census of 46 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 detached garage used for a maintenance shop and maintenance and facility storage, plus two detached wood framed sheds used for the water softener salt and activities supplies. Quality Review completed on 09/27/24			
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lighting Based on record review, observation, and	K 0291	Please accept the following as the	10/31/2024

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	interview; the facility failed to ensure there was documentation for the testing of 4 of 4 battery backup lights that were tested monthly for 30 seconds during 1 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 09/23/24 between 9:00 a.m. and 1:00 p.m. with the Maintenance Director and Human Resources Director 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 for August of 2024. Based on an interview at the time of record review, the Maintenance Director agreed the PM form for the battery powered emergency lights did not include 30 second monthly test for August of 2024. During a tour of the facility with the Maintenance Director and Maintenance Assistant between 1:00 p.m. and 3:00 p.m., the facility was equipped with four emergency battery powered lights.		facility's credible allegation of compliance (please note that this POC is submitted per State and Federal requirements only. It should not be construed as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation): 1.The following corrective action(s) have been taken as follows: A The facility has completed, and documented, 30 second monthly testing of battery powered emergency lights (see Exhibit K291 A). 1.All residents have the potential to be affected by this alleged deficient practice. 1.The following measures have been taken to ensure that this alleged deficient practice does not recur: A The Maintenance staff has been inserviced regarding the importance of performing and documenting the thirty (30) second monthly testing of all battery powered emergency lights. See exhibit K291 B. 1.The following Quality Monitoring program has been implemented to assure that	

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	This finding was reviewed with the Maintenance Director, Business Office Manager, Interim Director of Nursing, Nurse Consultant, and Human Resources Director during the exit conference. 3.1-19(b)		corrective actions are achieved, effective and sustained: A The Maintenance Supervisor and/or appointed designee(s) shall monitor that monthly 30 second testing of emergency battery powered lighting has been completed and documented. This monitoring shall be completed monthly for a minimum of sixty (60) days and may continue longer until sustained compliance is achieved. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s). 5	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other 1. Based on observation and interview, the facility failed to ensure at least 25 of 50 resident room battery operated smoke alarms were maintained. NFPA 72, 2010 Edition, Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect all residents, staff and visitors. Findings include:	K 0300	Please accept the following as the facility's credible allegation of compliance (please note that this POC is submitted per State and Federal requirements only. It should not be construed as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation): 1.The following corrective action(s) have been taken as follows:	10/31/2024

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	Based on observations on 09/23/24 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director and Maintenance Assistant, manufacturer's documentation affixed to the battery operated smoke alarms had manufacture dates of 2003 or 2013 in at least 25 resident rooms. Based on interview at the time of the observations, the Maintenance Director and Maintenance Assistant confirmed that many smoke alarms were more than ten years old and was unaware of the requirement to replace after 10 years from date of manufacture. This finding was reviewed with the Maintenance Director, Business Office Manager, Interim Director of Nursing, Nurse Consultant, and Human Resources Director during the exit conference. 3.1-19(b) 2. Based on record review, observation, and interview; the facility failed to ensure documentation for the preventative maintenance of all battery operated smoke alarms in resident rooms was available for 1 of 12 months. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, 29.10 Maintenance and Tests states fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents,		A The facility has replaced battery operated smoke alarms in resident rooms that were ten or more years old. See Exhibit K300 A – invoice of newly purchased battery-operated smoke alarms. B The facility has completed a monthly test on all resident room battery-powered smoke alarms. See Exhibit K300 B 1.All residents have the potential to be affected by this alleged deficient practice. The facility has checked all other battery-operated smoke alarms and have replaced those 10 years or older. 1.The following measures have been taken to ensure that this alleged deficient practice does not recur: A The Maintenance staff has been inserviced regarding the importance of replacing battery-powered smoke alarms that are 10 or more years old. Inservicing was also given regarding the requirement to perform monthly testing of battery-powered smoke alarms and to maintain a record of this testing. See Exhibit K300 C 1.The following Quality Monitoring program has been implemented to assure that corrective actions are achieved,	

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	staff, and visitors. Findings include: Based on record review on 09/23/24 between 9:00 a.m. and 1:00 p.m. with the Maintenance Director and Human Resources Director present, the facility was able to provide a preventative maintenance report that all resident room battery powered smoke alarms were tested on a monthly basis, however, there were no tests performed since 07/03/24. This was confirmed by the Maintenance Director at the time of record review. During a tour of the facility with the Maintenance Director between 1:00 p.m. and 3:00 p.m., all resident sleeping rooms were equipped with battery powered smoke alarms. This finding was reviewed with the Maintenance Director, Business Office Manager, Interim Director of Nursing, Nurse Consultant, and Human Resources Director during the exit conference. 3.1-19(b)		effective and sustained: A The Maintenance Supervisor and/or appointed designee(s) shall monitor that monthly testing of battery-powered smoke alarms has been completed, documented, and that battery-powered smoke alarms 10 year or older have been replaced. This monitoring shall be completed monthly for a minimum of sixty (60) days and may continue longer until sustained compliance is achieved. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s).	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as a storage room door, would close completely and latch automatically. This deficient practice could at least 20 residents and staff. Findings include: Based on observations on 09/23/24 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director and Maintenance	K 0321	Please accept the following as the facility's credible allegation of compliance (please note that this POC is submitted per State and Federal requirements only. It should not be construed as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation):	10/31/2024

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	Assistant, the Medical Supply storage room corridor door was provided with a self closing device, however, when tested several times, the door did not close completely and latch. The room was over 50 square feet in size and stored several shelves of cardboard boxes, paper, and plastic items, along with other combustible items. Based on interview at the time of observation, the Maintenance Assistant acknowledged that the Medical Supply storage room door did not close completely and latch automatically when tested several times. This finding was reviewed with the Maintenance Director, Business Office Manager, Interim Director of Nursing, Nurse Consultant, and Human Resources Director during the exit conference. 3.1-19(b)		1.The following corrective action(s) have been taken as follows: A The facility has repaired the self-closing device on the Medical Supply storage room corridor door and it is now completely closing and latching appropriately. Please see Exhibit K321 A – picture of repaired latch. 1.All residents have the potential to be affected by this alleged deficient practice. The facility has checked all other doors to hazardous areas to ensure that they completely close and latch appropriately. 1.The following measures have been taken to ensure that this alleged deficient practice does not recur: A The Maintenance staff has been inserviced regarding the requirement that hazardous areas must be 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	

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			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. Specific discussion was given to ensuring affected doors close and latch completely. Please see Exhibit K321 B. 1.The following Quality Monitoring program has been implemented to assure that corrective actions are achieved, effective and sustained: A The Maintenance Supervisor and/or appointed designee(s) shall monitor via two (2) weekly random door inspections to ensure that doors equipped with self-closing, self-latching devices close and latch properly. This monitoring shall be completed monthly for a minimum of sixty (60) days and may continue longer until sustained compliance is achieved. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s).	
K 0324 SS=F Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility	K 0324	Please accept the following as the	10/31/2024

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	failed to ensure staff were instructed in the proper use of the UL 300 hood fire suppression system in 1 of 1 kitchen. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 10.5.7 states instruction shall be provided to employees regarding the proper use of portable fire extinguishers and the manual activation of fire-extinguishing equipment. Section 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect kitchen staff plus all residents while in the adjacent dining room. Findings include: Based on observations on 09/23/24 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director and Maintenance Assistant, the kitchen was provided with a UL 300 hood system. Based on interview with the Kitchen Manager, when asked what they would do first if there was a fire underneath the range hood and the range hood suppression system had not automatically activated, The Kitchen Manager said she would first shut off the gas to the stove and then pointed to the K Class fire extinguisher close to the stove. She did not say she would pull the range hood fire suppression system pull station. When asked if she knew about the range hood fire suppression system pull station, she said no. This was acknowledged by the Maintenance Director at the time of observation and interview with the Kitchen Manager. This finding was reviewed with the Maintenance Director, Business Office Manager, Interim		facility's credible allegation of compliance (please note that this POC is submitted per State and Federal requirements only. It should not be construed as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation): 1.The following corrective action(s) have been taken as follows: A The kitchen manager has been provided 1:1 inservice training regarding range fires and emergency procedures. Specific discussion was given to the range hood suppression system pull station and its use. See Exhibit K324 A. 1.The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. 1.The following measures have been taken to assure that this alleged deficient practice does not recur: A The Maintenance Supervisor, Dietary Supervisor, and dietary staff have been inserviced regarding the procedures for range fires. Emphasis was given to manually deploying the ansul system (range hood suppression	

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	Director of Nursing, Nurse Consultant, and Human Resources Director during the exit conference. 3.1-19(b)		system pull station) if it does not deploy automatically. See Exhibit K324 B 1.The following Quality Monitoring program has been implemented to assure that corrective actions are achieved, effective and sustained: A The Administrator and/or appointed designee(s) shall randomly question a minimum of two (2) dietary employees each week regarding kitchen fires and procedures to follow. This shall be performed for a minimum of thirty (30) days and may be extended longer until staff consistently evidence competence. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s).	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance 1. Based on record review and interview, the facility failed to ensure the annual testing of all devices connected to 1 of 1 fire alarm system was performed. NFPA 72, National Fire Alarm Code, the 2010 Edition, at 14.6.2.4 requires a record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 14.6.2.4: (1) Date	K 0345	Please accept the following as the facility's credible allegation of compliance (please note that this POC is submitted per State and Federal requirements only. It should not be construed as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation):	10/31/2024

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	(2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency (ies) (7) Designation of the detector(s) tested (8) Functional test of detectors (9)*Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Functional test of mass notification system control units (13) Functional test of signal transmission to mass notification systems (14) Functional test of ability of mass notification system to silence fire alarm notification appliances (15) Tests of intelligibility of mass notification system speakers (16) Other tests as required by the equipment manufacturer's published instructions (17) Other tests as required by the authority having jurisdiction (18) Signatures of tester and approved authority representative (19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place) This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 09/23/24 between 9:00		1.The following corrective action(s) have been taken as follows: A The facility has found the a). annual fire alarm inspection and test; b). the semi-annual visual inspection; and c). the 2-year smoke detector sensitivity to be completed by contracted vendor. See Exhibit K345 A. 1.The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. 1.The following measures have been taken to assure that this alleged deficient practice does not recur: A Maintenance staff has been inserviced regarding the importance of testing and maintaining the fire alarm system 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. The requirement to maintain records of system acceptance, maintenance and testing must be readily available for review was also reviewed. Please see Exhibit K345 B 1.The following Quality	

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	a.m. and 1:00 p.m. with the Maintenance Director and Human Resources Director present, the facility was unable to provide an annual fire alarm system inspection/test report performed during the past 12 month period. Based on interview at the time of record review, the Human Resources Director was able to produce invoices dated 04/29/24 and 07/03/24 to show billing charges for quarter fire alarm system inspection reports, but was unable to produce the quarter fire alarm system inspection reports. This finding was reviewed with the Maintenance Director, Business Office Manager, Interim Director of Nursing, Nurse Consultant, and Human Resources Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all occupants. Findings include:		Monitoring program has been implemented to assure that corrective actions are achieved, effective and sustained: A The Administrator and/or appointed designee(s) shall review during scheduled QAPI meetings the status of a). annual fire alarm inspections and tests; b). the semi-annual visual inspections; and c). the 2-year smoke detector sensitivity testing. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s).	

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	Based on record review on 09/23/24 between 9:00 a.m. and 1:00 p.m. with the Maintenance Director and Human Resources Director present, there was no fire alarm system semi-annual visual inspection documentation available for review. Based on interview at the time of record review, the Human Resources Director was able to produce invoices dated 04/29/24 and 07/03/24 to show billing charges for quarter fire alarm system inspection reports, but was unable to produce the quarter fire alarm system inspection reports. This finding was reviewed with the Maintenance Director, Business Office Manager, Interim Director of Nursing, Nurse Consultant, and Human Resources Director during the exit conference. 3.1-19(b) 3. Based on record review and interview, the facility failed to ensure documentation was available to show that all smoke detectors were sensitivity tested within the past 24 months. 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			

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	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 detector. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 09/23/24 between 9:00 a.m. and 1:00 p.m. with the Maintenance Director and Human Resources Director present, the facility was unable to produce a smoke detector sensitivity report for all smoke detectors for the past 24 month period. The most recent smoke detector sensitivity test report for the facility's 30 hard wired smoke detectors was dated 06/24/22. Based on interview at the time of record review, the Maintenance Director confirmed there was no smoke detector sensitivity testing documentation available for the past 24 months. This finding was reviewed with the Maintenance Director, Business Office Manager, Interim			

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	Director of Nursing, Nurse Consultant, and Human Resources Director during the exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 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 2 of 4 quarters for 1 of 1 sprinkler system. 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	Please accept the following as the facility's credible allegation of compliance (please note that this POC is submitted per State and Federal requirements only. It should not be construed as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation): 1.The following corrective action(s) have been taken as follows: A The facility has obtained the vendor reports for the : a). a quarterly sprinkler inspection, and b). a 5-year automatic sprinkler piping system inspection, and has established a regular schedule with the contracted service provider. Please see Exhibit K353 A. B The maintenance supervisor has completed a monthly sprinkler system control valve inspection and will continue to document that this has been completed each month. Please see Exhibit K353 B.	10/31/2024

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	Findings include: Based on review of the quarterly sprinkler system inspection records on 09/23/24 between 9:00 a.m. and 1:00 p.m. with the Maintenance Director and Human Resources Director present, there were no quarterly sprinkler system inspection reports available for the second and third quarters of 2024. The Human Resources Director was able to produce invoices dated 04/29/24 and 07/03/24 to show billing charges for quarter sprinkler reports, but was unable to produce the quarter sprinkler system inspection reports. Based on interview at the time of record review, the Human Resources Director confirmed there was no written documentation available to show the sprinkler system inspection reports for the second and third quarters of 2024. This finding was reviewed with the Maintenance Director, Business Office Manager, Interim Director of Nursing, Nurse Consultant, and Human Resources Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure documentation was available to show 1 of 1 automatic sprinkler piping system was inspected every five years in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 14.2.1 states an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence		1.The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. 1.The following measures have been taken to assure that this alleged deficient practice does not recur: A Maintenance staff has been educated and trained regarding the importance of ensuring quarterly sprinkler inspections, 5-year automatic sprinkler piping system inspections, and monthly sprinkler system control valve inspections are consistently performed and documented per regulation. Please see Exhibit K353 C.' 1.The following Quality Monitoring program has been implemented to assure that corrective actions are achieved, effective and sustained: A The Administrator and/or appointed designee(s) shall review during scheduled QAPI meetings the status/completion of a). annual fire alarm inspections and tests; b). the semi-annual visual inspections; c). the 2-year smoke detector sensitivity testing; d). the quarterly sprinkler inspections, d). the 5-year automatic sprinkler piping system inspections, and e). the monthly sprinkler system	

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	of foreign organic and inorganic material. Alternative nondestructive examination methods shall be permitted. Non-metallic pipe shall not be required to be inspected internally. 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 affects all residents, staff and visitors. Findings include: Based on record review on 09/23/24 between 9:00 a.m. and 1:00 p.m. with the Maintenance Director and Human Resources Director present, documentation of an internal inspection of the sprinkler system performed within the most recent five year period was not available for review. Based on interview at the time of record review, the Maintenance Director said he has only been the Maintenance Director at the facility since mid August of 2024 and has not seen a report for an internal pipe inspection for the past five year period. This finding was reviewed with the Maintenance Director, Business Office Manager, Interim Director of Nursing, Nurse Consultant, and Human Resources Director during the exit conference. 3.1-19(b) 3. Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 dry sprinkler system during 12 of the past 12 months for the sprinkler system's control valves. NFPA 25, Standard for the Inspection, Testing,		control valve inspections. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s).	

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	and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. 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 record review on 09/23/24 between 9:00 a.m. and 1:00 p.m. with the Maintenance Director and Human Resources Director present, there was no monthly sprinkler system control valves inspection documentation for 12 of the past 12 months available to review. Based on interview at the time of record review, the Maintenance Director said he does inspect the sprinkler control valves on a weekly basis along with the sprinkler gauges, but does not document the control valves as having been inspected. This finding was reviewed with the Maintenance Director, Business Office Manager, Interim Director of Nursing, Nurse Consultant, and Human Resources Director during the exit conference. 3.1-19(b)			

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K 0355 SS=C Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to inspect all portable fire extinguishers during 1 of the past 12 months. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device/system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push to-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient	K 0355	Please accept the following as the facility's credible allegation of compliance (please note that this POC is submitted per State and Federal requirements only. It should not be construed as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation): 1.The following corrective action(s) have been taken as follows: A Maintenance staff has inspected all portable fire extinguishers and will continue to do so monthly per this requirement. See Exhibit K355 A 1.The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. 1.The following measures have been taken to assure that this alleged deficient practice does not recur: A Maintenance staff has been educated and trained regarding the requirement that portable fire extinguishers are selected, installed, inspected, and maintained in accordance with	10/31/2024

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	practice could affect all residents, staff and visitors. Findings include: Based on observations on 09/23/24 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director and Maintenance Assistant, all portable fire extinguishers in the facility were not inspected monthly in August of 2024. The annual inspection of this fire extinguisher by the facility's vendor was performed in July of 2024. Based on interview at the time of observations, the Maintenance Director acknowledged all portable fire extinguisher in the facility had not been inspected monthly in August of 2024. This finding was not reviewed during the exit conference, but was acknowledged by the Maintenance Director and Maintenance Assistant during the tour of the facility. 3.1-19(b)		NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10. Please see Exhibit K355 B. 1.The following Quality Monitoring program has been implemented to assure that corrective actions are achieved, effective and sustained: A The Administrator and/or appointed designee shall randomly inspect a minimum of two (2) portable fire extinguishers each week to ensure that there is documentation that they have been inspected each month. This shall be ongoing for a minimum 8 weeks and may continue until consistent compliance is established. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s).	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 2 of over 10 wet locations, was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in	K 0511	Please accept the following as the facility's credible allegation of compliance (please note that this POC is submitted per State and Federal requirements only. It should not be construed as the facility's admission of non-compliance with any State or	10/31/2024

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	210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical		Federal standard, requirement or regulation): 1.The following corrective action(s) have been taken as follows: A The electric receptacle within three feet to the right of the sink in the West Pantry Room was replaced with a receptacle that provides GFCI protection. B The electric receptacle within three feet to the right of the prep sink in the Kitchen was replaced with a receptacle that provides GFCI protection. Please see Exhibit K511 A #1 & #2 (pictures of replaced receptacles). 1.The facility recognizes that all residents have the potential to be affected by this alleged deficient practice and has checked all wet locations to ensure they are equipped with GFCI receptacles as required. 1.The following measures have been taken to ensure that this alleged deficient practice does not recur: A Maintenance staff has been educated and trained regarding the requirement to ensure wet locations are provided with ground fault circuit interrupters (GFCI)	

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	care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff while in the West Pantry Room and kitchen staff. Findings include: Based on observations on 09/23/24 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director and Maintenance Assistant, the following was noted: a. The electric receptacle within three feet to the right of the sink in the West Pantry Room was not provided with GFCI protection. When tested with a GFCI testing device the receptacle did not break the electrical circuit. b. The electric receptacle within three feet to the right of the prep sink in the Kitchen was not provided with a GFCI receptacle. When tested with a GFCI testing device the receptacle did not break the electrical circuit. Based on interview at the time of each observation, the Maintenance Director agreed the receptacles near the two sinks noted were not properly GFCI protected. This finding was reviewed with the Maintenance		protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Please see Exhibit K511 B. 1.The following Quality Monitoring program has been implemented to assure that corrective actions are achieved, effective and sustained: The Administrator and/or appointed designee shall randomly inspect a minimum of two (2) receptacles near wet areas each week to ensure that they are equipped with GFCI protected receptacles. This shall be ongoing for a minimum 8 weeks and may continue until consistent compliance is established. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s).	

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	Director, Business Office Manager, Interim Director of Nursing, Nurse Consultant, and Human Resources Director during the exit conference. 3.1-19(b)			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 3 of 3 shifts during 4 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 09/23/24 between 9:00 a.m. and 1:00 p.m. with the Maintenance Director and Human Resources Director present, the facility was only able to provide six documented fire drill reports for the past 12 month period. The following shifts and quarters were missing fire drill reports: a. The first shift (day) of the third quarter (July, August, and September) of 2023 and so far in 2024, and fourth quarter (October, November, and December) of 2023. b. The second shift (evening) of the third quarter (July, August, and September) of 2023 and so far in 2024, and fourth quarter (October, November, and December) of 2023. c. The third shift (night) of the third quarter (July, August, and September) of 2023 and so far in 2024, and fourth quarter (October, November, and December) of 2023, and first quarter (January, February, and March), and second quarter (April, May, and June) of 2024. Based on interview at the time of record review,	K 0712	Please accept the following as the facility's credible allegation of compliance (please note that this POC is submitted per State and Federal requirements only. It should not be construed as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation): 1.The following corrective action(s) have been taken as follows: A The facility has held a fire drill for all shifts. Please see Exhibit K712 A 1.The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. 1.The following measures have been taken to assure that this alleged deficient practice does not recur: A The Maintenance Supervisor	10/31/2024

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	the Maintenance Director and Human Resources Director confirmed the lack of fire drill reports for the previously mentioned shifts and quarters. This finding was reviewed with the Maintenance Director, Business Office Manager, Interim Director of Nursing, Nurse Consultant, and Human Resources Director during the exit conference. 3.1-19(b) 3.1-51(c)		has been inserviced regarding the importance of regularly holding fire drills a minimum of quarterly for each shift to ensure staff competency and compliance with fire emergency policies and procedures. Please see Exhibit K712 B B The facility has implemented a planned fire drill calendar to ensure that drills are being held in compliance with this requirement. 1.The following Quality Monitoring program has been implemented to assure that corrective actions are achieved, effective and sustained: The Administrator and/or appointed designee(s) shall monitor the fire drill calendar to ensure that drills are being held for each shift per requirements. This monitoring shall be ongoing for a minimum of sixty (60) days and may continue longer until consistent compliance has been sustained. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s).	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste 1. Based on record review and interview, the	K 0918	Please accept the following as the	10/31/2024

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	facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 1 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 all residents, staff and visitors. Findings include: Based on review of the generator inspection and testing reports on 09/23/24 between 9:00 a.m. and 1:00 p.m. with the Maintenance Director and Human Resources Director present, there was no monthly generator load test documentation available for August, and so far in September of 2024 for the emergency generator. Based on		facility's credible allegation of compliance (please note that this POC is submitted per State and Federal requirements only. It should not be construed as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation): 1.The following corrective action(s) have been taken as follows: A The facility has completed, and documented in written form: a monthly generator load test. (see Exhibit E041/K918 A) and a weekly generator inspection (see Exhibit E041/K918 B) 1.All residents have the potential to be affected by this alleged deficient practice. 1.The following measures have been taken to ensure that this alleged deficient practice does not recur: A The Maintenance staff has been inserviced regarding the requirement to complete monthly generator load testing and weekly generator inspections per requirements of E041. Specific discussion was given to maintaining a written rcord of	

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	interview at the time of record review, the Maintenance Director said he has only been in his current position as Maintenance Director since mid August of 2024 and has only performed the monthly load test one time, but only documented it in his notes as "Generator Ran for Test", with no other information provided. This finding was reviewed with the Maintenance Director, Business Office Manager, Interim Director of Nursing, Nurse Consultant, and Human Resources Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 1 generator was maintained for 24 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 all residents, staff and visitors. Findings include:		these tests and inspections. See EXHIBIT E041/K918 C B 1.The following Quality Monitoring program has been implemented to assure that corrective actions are achieved, effective and sustained: The Maintenance Supervisor and/or appointed designee(s) shall monitor that weekly generator inspections and monthly generator load tests have been completed and documented. This monitoring shall be completed monthly for a minimum of sixty (60) days and may continue longer until sustained compliance is achieved. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 01 B. WING	09/23/2024

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	Based on review of the generator inspection and testing reports on 09/23/24 between 9:00 a.m. and 1:00 p.m. with the Maintenance Director and Human Resources Director present, there was no documentation available to show the emergency generator was inspected/tested weekly since April 10, 2024. Based on interview at the time of record review, the Maintenance Director confirmed there was no weekly inspection/testing documentation available for review. This finding was reviewed with the Maintenance Director, Business Office Manager, Interim Director of Nursing, Nurse Consultant, and Human Resources Director during the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure power strips and multi plugged adapters were not used as a substitute for fixed wiring in 1 of 50 resident rooms and two staff/resident areas. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect at least 5 residents and staff. Findings include: Based on observations on 09/23/24 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with	K 0920	Please accept the following as the facility's credible allegation of compliance (please note that this POC is submitted per State and Federal requirements only. It should not be construed as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation): 1.The following corrective action(s) have been taken as follows: A The multi-plug adapter observed with the microwave oven plugged into it in the 300 Hall	10/31/2024

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	155370	A. BUILDING 01 B. WING	09/23/2024

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	the Maintenance Director and Maintenance Assistant, the following was noted: a. There was a microwave oven plugged into a multi plugged adapter in the 300 Hall Pantry. The Maintenance Assistant removed the multi plugged adapter at the time of observation. b. There was a small refrigerator plugged into a power strip in the Activities Room. The Maintenance Assistant removed the power strip at the time of observation. c. There was a small refrigerator plugged into a power strip in resident room 101. The Maintenance Assistant removed the power strip at the time of observation. Based on interview at the time of each observation, the Maintenance Director and Maintenance Assistant acknowledged the use of the power strips and multi plugged adapter. This finding was reviewed with the Maintenance Director, Business Office Manager, Interim Director of Nursing, Nurse Consultant, and Human Resources Director during the exit conference. 3.1-19(b)		Pantry was removed at the time of observation by the maintenance assistant as noted in the 2567. B The multi-plug adapter observed with the refrigerator plugged into it in the Activities Room. was removed at the time of observation by the maintenance assistant as noted in the 2567. C The multi-plug adapter observed with the refrigerator plugged into it in resident room 101 was removed at the time of observation by the maintenance assistant as noted in the 2567. 2 The facility identifies all residents as having the potential to be affected by this deficient practice. Maintenance staff shall monitor compliance via routine facility inspection rounds. 1.The following measures have been taken to ensure that this alleged deficient practice does not recur: A The Maintenance staff has been inserviced regarding the requirement to ensure power strips and multi plugged adapters were not used as a substitute for fixed wiring unless specifically permitted. See Exhibit K920 A. 1.The following Quality Monitoring program has been implemented to assure that corrective actions are achieved,	

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			effective and sustained: A The Maintenance Supervisor and/or appointed designee(s) shall monitor via weekly facility rounds that there are no power strips or multi plugged adapters in use. This monitoring shall be completed weekly for a minimum of thirty (30) days and may continue longer until sustained compliance is achieved. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s).	