STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155850	A. BUILDING -- B. WING	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELLTOWER HEALTH & REHABILITATION CENTER	5805 NORTH FIR ROAD GRANGER, IN 46530

(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: 10/03/22 Facility Number: 013644 Provider Number: 155850 AIM Number: 201381180 At this Emergency Preparedness survey, Belltower Health & Rehabilitation Center 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 85. Quality Review completed on 10/07/22	E 0000		
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable			

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

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	Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (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 all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [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. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to review and update the Emergency	E 0004	1. The Emergency Preparedness Plan was updated	11/10/2022

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	Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 10/03/22 at 10:11 a.m., the EEP Update and Review form had a revise and review date of 09/18/20, no other documentation could be found to show the EPP was reviewed and updated within the last year. Based on an interview during records review, the Administrator and Maintenance Director stated the documentation to show the EEP has been reviewed or updated within the last year could not be found. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		annually with the signature pages added to the plan. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. Facility staff have been educated on the updated plan by 11.10.22. The education will be conducted by the Administrator and the Director of Clinical Education. 4. The emergency plan will be reviewed by the QAPI committee on an annual basis. 5. Date of Compliance 11.10.22	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [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			

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	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. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility 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 annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization 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 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must			

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	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. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 10/03/22 at 10:11 a.m., the EEP Update and Review form had a revise and review date of 09/18/20, no other documentation could be found to show the EPP Policies and Procedures were reviewed and updated within the last year. Based on an interview during records review, the Administrator and Maintenance Director stated the documentation to show the EEP Policies and Procedures have been reviewed or updated within the last year could not be found. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0013	1. The Emergency preparedness plan was updated annually with the signed signature page added to the plan. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. Facility staff have been educated on the updated plan by 11.10.22. The education will be conducted by the Administrator and the Director of Clinical Education. 4. The emergency plan will be reviewed by the QAPI committee on an annual basis. 5. Date of Compliance 11.10.22	11/10/2022

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E 0015 SS=C Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1) Subsistence Needs for Staff and Patients §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [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 every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements			

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	for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 10/03/22 at 10:20 a.m., the subsistence needs documentation for the emergency preparedness program was incomplete.	E 0015	1. The Existing plan has been modified to include sewage and waste outages. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. Facility staff have been educated on the revised policy that includes sewage and waste by 11.10.22. This education will be conducted by the Administrator and the Director of Clinical Education. 4. The emergency plan will be reviewed by the QAPI committee on an annual basis. 5. Date of Compliance 11.10.22	11/10/2022

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	Documentation for sewage and waste outage was not available for review. Based on interview at the time of records review, the Maintenance Director and the Administrator stated the sewage and waste outage policy could not be found. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.			
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Communications Program at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator	E 0029	1. The emergency preparedness plan was updated annually with signed signature page. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice.	11/10/2022

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	and Maintenance Director on 10/03/22 at 10:11 a.m., the EEP Update and Review form had a revise and review date of 09/18/20, no other documentation could be found to show the EPP Communications Program was reviewed and updated within the last year. Based on an interview during records review, the Administrator and Maintenance Director stated the documentation to show the EEP Communications Program has been reviewed or updated within the last year could not be found. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		3. Facility staff have been educated on the Emergency Preparedness Plan by 11.10.22. The education was conducted by the Administrator and Director of Clinical Education. 4. The emergency plan will be reviewed by the QAPI committee on an annual basis. 5. Date of Compliance 11.10.22	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth			

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	in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing			

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	and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Training and Testing Program at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 10/03/22 at 10:11 a.m., the EEP Update and Review form had a revise and review date of 09/18/20, no other documentation could be found to show the EPP Training and Testing Program was reviewed and updated within the last year. Based on an interview during records review, the Administrator and Maintenance Director stated the documentation to show the EEP Training and Testing Program has been reviewed or updated within the last year could not be found. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0036	1. The Emergency preparedness plan was updated annually with the signed signature page added to the plan. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. Facility staff have been educated on the updated plan by 11.10.22. The education will be conducted by the Administrator and the Director of Clinical Education. 4. The emergency plan will be reviewed by the QAPI committee on an annual basis. 5. Date of Compliance 11.10.22	11/10/2022
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1)			

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	EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures.			

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

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	services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training.			

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

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	procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Administrator and Maintenance Director on 10/03/22 at 12:21 a.m., no documentation of annual EEP training and no documentation to show staff could demonstrate knowledge of the EPP was available for review. Based on an interview at the time of records review, the Maintenance Director stated EEP training has not been conducted with in the last 12 months. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0037	1. The Emergency preparedness plan has been reviewed with current staff. New hires of the facility will receive emergency preparedness training during scheduled orientation. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. Facility staff have been educated on the Emergency Preparedness Plan by 11.10.22. The education will be conducted by the Administrator and the Director of Clinical Education. 4. The emergency plan will be reviewed by the QAPI committee on an annual basis. 5. Date of Compliance 11.10.22	11/10/2022

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E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is			

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	community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and 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 [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based			

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	functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and 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. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice 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; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop 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.			

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	(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] 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; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and 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 [facility's] response to and maintain documentation of all drills,			

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	tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization 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; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and 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 PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise			

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	the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] 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] 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 a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual 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; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator 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] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.			

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	*[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID 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; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual 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; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and 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 ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the			

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	following: (i) Participate in a 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 every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, 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; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and 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 HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise			

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	or workshop at least annually. A tabletop exercise is led by a facilitator and 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. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. 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	E 0039	1. The Facility has contacted the local fire department and are awaiting an official date. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be	11/10/2022

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	155850	A. BUILDING -- B. WING	10/03/2022

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	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. (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. Findings include: Based on record review with the Administrator and the Maintenance Director on 10/03/22 at 10:19 a.m., no documentation of a community based annual exercise, an actual natural or man-made emergency, or an annual individual facility-based functional exercise if a community drill is not available was available for review. Also, documentation of an additional annual exercise of		affected deficient practice. 3. Facility staff will be educated on the community-based training either live training and/or table top exercise. This training will be conducted by local fire department and/or Director of Clinical Education. This education will be conducted by 11.10.22 4. The Emergency plan will be reviewed by the QAPI committee on an annual basis. 5. Date of Compliance 11.10.22	

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	choice within the last year was not available for review. Based on interview at the time of records review, the Maintenance Director stated both required exercises have not been conducted within the last 12 months. This finding was reviewed with the Administrator and Maintenance 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 483.90(a). Survey Date: 10/03/22 Facility Number: 013644 Provider Number: 155850 AIM Number: 201381180 At this Life Safety Code survey, Belltower Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, the 2012 edition of NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) and 410 IAC 16.2. The facility was surveyed with Chapter 19, Existing Health Care Occupancies. This one-story facility contains two different occupancies separated by two separate two hour separations. The health care section was determined to be of Type V (111) construction and fully sprinklered. The offices and residential dining room was surveyed under	K 0000		

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	Business/Assembly chapters which was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in resident rooms, in corridors and in spaces open to the corridors. The facility has a capacity of 96 and had a census of 85 at the time of this survey. All areas where residents have customary access and all areas providing facility services were sprinklered. Quality Review completed on 10/07/22			
K 0341 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 #1. Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors.	K 0341	1. The Fire company has been contacted to repair the fire panel. The facility is awaiting confirmation date for scheduled repair once repaired the date & time will be corrected as well as the trouble light off. The smoke detector has been moved to	11/10/2022

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	Findings include: Based on observation on 10/03/22 at 12:15 p.m. with the Maintenance Director, the following was observed: a.) On the fire alarm control panel there was a yellow trouble light illuminated for one of the dialers. b.) The time on the fire alarm control panel indicated the time to be 12:15 a.m. when checked at 12:15 p.m. c.) The date on the fire alarm control panel indicated the date to be 06/28/22 when checked on 10/03/22. During an interview at the time of observation and testing, the Maintenance Director confirmed the yellow trouble light was for one of the dialers and agreed the time and date on the on the panel was incorrect. #2. Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was installed in accordance with 19.3.4.1. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 17.7.4.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 10/03/22 at 12:45 p.m., in the in B-hall by room #02 there was a smoke detector next to an		ensure it is not to close to the air exchange vent. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. The Maintenance Director has been educated by the administrator on the requirements as it relates to placement of smoke detectors and fire panel repair by 11.10.22. The Maintenance will audit the fire panel weekly and inform Administrator of any abnormal readings within the fire panel. 4. Fire panel audits will be forwarded to QAPI for review, results of these audits will be performed by the Maintenance Director monthly for a period of 6-months or until compliance is achieved. 5. Date of Compliance 11.10.22	

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	air return where air flow would prevent proper operation of the detector. The detector was about 12 inches from the vent. Based on interview at the time of observation, the Maintenance Director agreed the smoke detector was in the direct airflow from the return and was within 12 inches of the vent. The findings were reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)			
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems were maintained in accordance with LSC 9.6.1.3, NFPA 70 National Electrical Code, and NFPA 72 National Fire Alarm Code. NFPA 72, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. This deficient practice affects all occupants in the facility. Findings include:	K 0345	1. The Fire Alarm System has been scheduled for further testing which will include sensitivity testing. The past due fire alarm and sensitivity inspection has since surpassed therefore correction could not be made. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient	11/10/2022

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	During records review with the Maintenance Director on 10/03/22 at 11:15 a.m., the following tests and inspections were past due or missing: a.) The last annual fire alarm inspection was conducted on 4/28/21. b.) The last smoke detector sensitivity test was conducted on 4/28/20 c.) no documentation was provided regarding a visual inspection of the fire alarm system six months after the annual fire alarm inspection. Based on interview at the time of records review, the Maintenance Director stated inspection were not completed due to a switch of contractors. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		practice. 3. The Maintenance Director has been education on the frequency of fire alarm testing as well as smoke detector sensitivity by 11.10.22. This education will be conducted by the Administrator 4. Fire Alarm reports and Sensitivity reports will be forwarded to QAPI for review. These reports will be reviewed monthly for a period of 12-months or until compliance is achieved. 5. Date of Compliance 11.10.22	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ 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			

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	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. 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. Findings include: Based on review of the quarterly sprinkler system inspection records with the Maintenance Director on 10/03/22 at 11:18 a.m., there was no quarterly sprinkler system inspection report available for the second quarter (April, May, and June) of 2022. Based om interview at the time of record review, the Maintenance Director stated there was no written documentation available to show the	K 0353	1. The Quarterly Sprinkler inspection has been requested and facility is awaiting date from provider. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. The Maintenance Director has been educated on the requirement as it relates to Sprinkler inspections on a quarterly basis by 11.10.22 4. Sprinkler inspection reports will be forwarded to QAPI for review. Results of those reports will be submitted quarterly for a period of 12-months or until compliance is achieved. 5. Date of Compliance 11.10.22	11/10/2022

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	sprinkler system had been inspected during the second quarter of 2022. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)			
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation, and interview; the facility failed to ensure 1 of 1 fire damper systems were inspected and provided necessary maintenance after the first year after instillation and at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be	K 0521	1. 1. The Smoke Damper inspection has been requested and is waiting for an official date for said inspection. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. The Maintenance Director has been educated on the frequency of smoke damper inspections. This education will be conducted by the administrator by 11.10.22 4. Smoke Damper inspection reports will be reviewed by the QAPI Committee. These will be reviewed on an annual basis. 5. Date of Compliance 11.10.22	11/10/2022

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	documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents. Findings include: Based on records review with the Maintenance Director on 10/03/22 at 11:50 a.m., no documentation was provided to show if the building's smoke/fire damper have ever been inspected. Based on observation with the Maintenance Director between 12:00 p.m. and 1:00 p.m., there were smoke/fire dampers in the duct work. Based on interview at the time of records review and observations, the Maintenance Director stated the damper inspection could not be found and did not know if the damper were ever inspected. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)			
K 0522 SS=E Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate			

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	from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms were provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for all staff in the laundry room. Findings include: Based on observation with the Maintenance Director and the Administrator on 10/03/22 at 12:20 p.m., the laundry room had fuel-fired dryers with a fresh air intake that had automatic louvers that would open when the dryers are running, but when a dryer was turned on the louvers did not open. This condition does not allow for fresh air to completely enter the room when the dryers are turned on. Based on an interview at the time of observation, the Maintenance Director stated the louvers over the fresh air intake did not open automatically when the dryers are turned on. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)	K 0522	1. The Dryer louvers has been repaired and are now functioning to control the air flow behind the dryers. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. The Maintenance Director has been educated by the Administrator on the requirement of heating devices with an emphasis on dryer louvers by 11.10.22. 4. The dryer louvers will be audited on a monthly basis. Results of those audits will be forwarded to QAPI for review, this will take place monthly for a period of 6-months or until compliance is achieved. 5. Date of Compliance 11.10.22	11/10/2022
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The			

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	plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide 1 of 1 written emergency fire safety plan that incorporated all items listed in NFPA 101, Section 19.7.2.2. 1. Use of alarms. 2. Transmission of alarms to fire department. 3. Emergency phone call to fire department 4. Response to alarms. 5. Isolation of fire. 6. Evacuation of immediate area. 7. Evacuation of smoke compartment. 8. Preparation of floors and building for evacuation. 9. Extinguishment of fire. This deficient practice affects all residents, staff and visitors in the event of an emergency. Findings include: Based on records review with the Maintenance Director on 10/03/22 at 10:37 a.m., the provided facility's fire safety plan did not address the following items: a) Isolation of fire. The facility did not address how to isolate a fire. b) Evacuation of immediate area. The facility did not address evacuating residents from the affected area. c) Preparation of floors and building for evacuation. The facility did not address removing wheeled patient equipment from the corridors and evacuation routs during a fire evacuation. d) Evacuation of smoke compartment. The facility	K 0711	1. The Current policy has been revised to include the RACE method for the fire safety plan. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. Facility staff has been educated on the revisions to the fire safety plan by 11.10.22. This education will be conducted by the Administrator and Director of Clinical Education. Current facility policy will be reviewed annually along with the emergency preparedness plan. 4. The revised policy will be forwarded to QAPI for review. Emergency preparedness plan will be reviewed annually as required. 5. Date of Compliance 11.10.22	11/10/2022

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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
	did not address evacuating residents from one smoke compartment to another non-effected smoke compartment. Based on interview at the time of records review, the Maintenance Director looked through the plan and stated the aforementioned items were not in the provided plan. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)			
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.			

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	155850	A. BUILDING 01 B. WING	10/03/2022

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	(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview; the facility failed to ensure 1 of 1 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect staff and 10 residents in the courtyard. Findings include: Based on observation with the Maintenance Director on 10/03/22 at 12:18 p.m., outside the employee exit in the staff smoking area there were over 30 cigarette butts disposed on the ground around the exit and smoking area. Based on interview at the time of observations, the Maintenance Director agree there were cigarette butts on the ground in the staff smoking area. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)	K 0741	1. The cigarette buts were cleaned up immediately upon the discovery. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. Facility staff has been educated by the administrator on the requirement related to smoking and disposing them in a fire proof container. Maintenance will make daily rounds to ensure items are placed in the proper receptacle. Education will take place by 11.10.22 4. The Maintenance Director will audit cigarette buts on the ground and report findings to the QAPI for review. This will be reviewed monthly for a period of 6-months or until compliance is achieved. 5. Date of Compliance 11.10.22	11/10/2022
K 0754 SS=F Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5			

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	gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility failed to ensure trash/linen receptacles in 6 of 6 corridors were maintained in accordance with 19.7.5.7. This deficient practice could affect all residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 10/03/22 between 12:00 p.m. and 1:30 p.m., there were nine trash/linen carts in the all halls totaling more than 32-gallons. Based on interview at the time of observation, the Maintenance Director agreed there were trash/linen carts in the all halls greater than 32-gallons in capacity. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)	K 0754	1. The 32-gallon bags for the linen carts have been replaced with smaller gallon size bags as the facility has limited space for storage of current linen carts. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. Facility staff has been educated by the administrator on the requirements as it relates to linen carts being in the hallway and the reduction of bags provided to staff for use. This education will take place by 11.10.22 4. Maintenance will make weekly rounds to identify proper bag use and correct if discovered. Maintenance rounds will for forwarded to QAPI monthly for a period of 6-months or until	11/10/2022

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			compliance is achieved. 5. Date of Compliance 11.10.22	
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation, records review, and interview the facility failed to ensure 1 of 1 portable space heater elements was not used in an area where residents could be present, did not exceed 212 degrees Fahrenheit and had a written space heater policy. This deficient practice could affect up to 10 residents, staff, and visitors in the front lobby. Findings include: Based on observation during entrance of the facility on 10/03/22 at 09:35 a.m., a portable space heater with an unknown max temperature was in use on the reception desk where residents could be present. Based on records review at 10:00 a.m., no space heater policy was available for review. Based on interview at the time of the observation and records review, the Maintenance Director agreed a space heater was being used with an unknown max temperature and stated the facility did not have an space safety heater policy. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.	K 0781	1. The space heater was immediately removed upon the discovery. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. Facility staff has been educated by the administrator on space heater use. This education will be performed by 11.10.22. Maintenance will conduct weekly rounds to ensure no space heaters are in the facility. 4. Environmental rounds will be forwarded to QAPI monthly for a period of 6-months or until compliance is achieved. 5. Date of Compliance 11.10.22	11/10/2022

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	3.1-19(b)			
K 0914 SS=F 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. 6.3.4 (NFPA 99) Based on observation, record review and interview, the facility failed to ensure the hospital grade electrical receptacles in 17 of 17 resident sleeping rooms were tested after initial installation, replacement, or servicing of the device. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.1 states where hospital-grade receptacles are required at patient bed locations and in locations where deep sedation or general anesthesia is administered,	K 0914	1. The electrical outlets as identified has been inspected by the Maintenance Director. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. The Maintenance Director	11/10/2022

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	testing shall be performed after initial installation, replacement, or servicing of the device. 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 patients in the facility. Findings include: Based on observations with the Maintenance Director on 10/03/22 between 11:00 a.m. and 1:00 p.m., the facility's resident sleeping rooms contained four to six hospital grade electrical receptacles. Based on records review at 11:30 a.m., no documentation was available to show electrical receptacles in the sleeping rooms were tested after initial installation, replacement, or servicing of the device. Based on interview at the time of the observation and records review, the Maintenance Director confirmed all of the electrical receptacles in the sleeping rooms were hospital-grade and stated testing per NFPA 99, Receptacle Testing requirements has not been completed. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		has been educated by the administrator on the regulation as it relates to testing hospital grade outlets by 11.10.22 4. The electrical outlet inspection report will be forwarded to QAPI for review, this will be reviewed monthly for 3 months or until compliance is achieved. 5. Date of compliance 11.10.22	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag			

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	Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA			

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	99) Based on observation and interview, the facility failed to ensure 10 of 10 full and empty oxygen cylinders were separated and marked to avoid confusion. This deficient practice could affect up to 30 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director on 10/03/22 at 12:55 p.m., the oxygen storage room contained full and empty oxygen cylinders, but the cylinders were mixed together and not marked as full or empty. Based on interview at the time of observation, the Maintenance Director stated the cylinders were not marked as full and empty. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)	K 0923	1. The O2 cylinders have been separated and marked appropriately to include full or empty. New dividing racks has been placed in the O2 room to ensure separation. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. Facility staff has been educated on the requirement of keeping O2 tanks separated by full and empty as required. This education will be conducted by 11.10.22. Maintenance will perform weekly rounds to validate proper O2 storage separation. 4. Environmental rounds will be forwarded to QAPI monthly for a period of 6-months or until compliance is achieved. 5. Date of Compliance 11.10.22	11/10/2022