STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155145	A. BUILDING -- B. WING	08/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WASHINGTON NURSING CENTER	603 E NATIONAL HWY WASHINGTON, IN 47501

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/17/22 Facility Number: 000068 Provider Number: 155145 AIM Number: 100274980 At this Emergency Preparedness survey, Washington Nursing 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 a capacity of 140 certified beds and had a census of 37 at the time of this visit. Quality Review completed on 08/25/22 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	The creation and submission of this Plan of Correction (POC) does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this *CMS-2567 Plan of Correction* be considered the *Letter of Credible Allegation of Compliance* and requests a desk review in lieu of a post-survey review on, or after 09/09/2022.	
E 0013 SS=C 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).			

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

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	(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 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			

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	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 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 provide correct and current contact information for 1 of over 20 emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: Based on review of the Emergency Preparedness Plan (EPP) on 08/17/22 between 9:00 a.m. and 12:00 p.m. with the Administrator and Maintenance Supervisor present, there was documentation in the EPP for facility policies and procedures in the event of a facility gas leak, however the policy and procedure had the facility's former gas company listed with phone number instead of the current gas company and number. Based on	E 0013	Deficiency ID: E 013 *What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. The documentation in the EPP for facility policies and procedures in the event of a gas leak has been updated to include the correct name of the current gas company. Revisions have been noted in the Emergency Preparedness Planning &	09/09/2022

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	interview at the time of record review, the Administrator said she did review the entire EPP on 03/21/22, but must have missed the change in gas company's on the policy and procedure. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.		Resource Manual binder. **How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?* Washington Nursing Center will continue to review the Emergency Preparedness Binder at least monthly and updated revisions will be noted in the Emergency Preparedness Planning & Resource Manual binder. **What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Washington Nursing Center will continue to review the Emergency Preparedness Binder and updated revisions will be noted in the Emergency Preparedness Planning & Resource Manual binder. Documentation of all activities associated with this POC will be noted on the designee will be responsible for monitoring this POC to ensure its successful completion. **How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be	

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			monitored using the *Washington Nursing Center E013-20220817 Audit Tool*. Progress will be monitored five days a week for 1 month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. This will also be made part of the Washington Nursing Center Preventive Maintenance (PM) Plan. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or designee will review the audit tool(s) daily during Stand Up, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion. *	
E 0024 SS=C Bldg. --	403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 482.15(b)(6), 483.475(b)(6), 483.73(b)(6), 484.102(b)(5), 485.625(b)(6), 485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5) Policies/Procedures-Volunteers and Staffing §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph			

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	(a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect	E 0024	Deficiency ID: E 024 *_What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?_ It is the practice of this provider to ensure that federal participation	09/09/2022

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	all occupants. Findings include: Based on review of the Emergency Preparedness Plan on 08/17/22 between 9:00 a.m. and 12:00 p.m. with the Administrator and Maintenance Supervisor present, the facility's plan did not address the use of volunteers in an emergency. Based on interview at the time of review, the Maintenance Supervisor agreed the plan provided did not address the use of volunteers in an emergency. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.		requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. WNC did review and update documentation related to the need/use of volunteers in the event of an emergency. Documentation has been added to the EPP to address the use of volunteers in an emergency. *How will other residents having the potential to be affected by the same alleged deficient practice be identified and what Corrective action (s) will be taken?* Washington Nursing Center will continue to review the Emergency Preparedness Binder at least monthly and updated revisions will be noted. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Washington Nursing Center will continue to review the Emergency Preparedness Binder and updated revisions will be noted at least monthly. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or the designee will be responsible for monitoring this POC to ensure its successful completion.	

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			**How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be monitored using the *Washington Nursing Center E024-20220817 Audit Tool*. Progress will be monitored five days a week for 1 month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or designee will review the audit tool(s) daily during Stand Up, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion.	
E 0026 SS=C Bldg. --	403.748(b)(8), 416.54(b)(6), 418.113(b)(6)(C)(iv), 441.184(b)(8), 482.15(b)(8), 483.475(b)(8), 483.73(b)(8), 485.625(b)(8), 485.920(b)(7), 494.62(b)(7) Roles Under a Waiver Declared by Secretary §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7).			

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	[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.73(b)(8). This deficient practice could affect all occupants. Findings include:	E 0026	Deficiency ID: E026 **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* It is the practice of this provider to ensure that federal participation requirements for nursing homes	09/09/2022

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	Based on review of the Emergency Preparedness Plan on 08/17/22 between 9:00 a.m. and 12:00 p.m. with the Administrator and Maintenance Supervisor present, the plan did not address the role of the LTC facility under a waiver declared by the Secretary. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the available plan did not address the role of the LTC facility under a waiver declared by the Secretary. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.		participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. The documentation in the EPP for facility policies and procedures including the role of the LTC facility under the waiver in accordance with Section 1135 was located in the EP binder, but not in the designated spot. The waiver has been placed under tab labeled “1135 Waiver”. **How will other residents having the potential to be affected by the same alleged deficient practice be identified and what Corrective action (s) will be taken?* Washington Nursing Center will continue to review the Emergency Preparedness Binder at least monthly and updated revisions will be noted in the Emergency Preparedness Planning & Resource Manual binder. * *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* To ensure ongoing compliance, Washington Nursing Center will continue to review the Emergency Preparedness Binder and updated revisions will be	

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			noted at least monthly and as needed. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or the designee will be responsible for monitoring this POC to ensure its successful completion. This will be reviewed as part of the monthly Quality Assurance meeting and the plan of action adjusted accordingly, as warranted. **How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be monitored using the *Washington Nursing Center E026-20220817 Audit Tool*. Progress will be monitored 5 days a week for 1 month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or designee will review the audit tool(s) daily during Stand Up, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion.	

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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 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			

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	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 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 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.	E 0036	Deficiency ID: E 036 *What corrective action(s) will be accomplished for those residents found to have been affected by*	09/09/2022

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WASHINGTON NURSING CENTER	603 E NATIONAL HWY WASHINGTON, IN 47501

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	Findings include: Based on review of the Emergency Preparedness Plan (EPP) on 08/17/22 between 9:00 a.m. and 12:00 p.m. with the Administrator and Maintenance Supervisor present, there was no documentation available to show the facility had an emergency preparedness training and testing program available. Based on interview at the time of record review, the Administrator confirmed there is no training and testing program available within the EPP specific to the EPP. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.		*the alleged deficient practice?* It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. The documentation in the EPP for annual facility training and testing program has been reviewed and updated. All staff in-service scheduled for 09/08/2022. **How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?* Washington Nursing Center will continue to review the Emergency Preparedness Binder at least monthly and updated revisions will be noted as needed. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* To ensure ongoing compliance, Washington Nursing Center will continue to review the Emergency Preparedness Binder and updated revisions will be noted at least monthly and as needed. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or the designee will be responsible for	

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			monitoring this POC to ensure its successful completion. This will be reviewed as part of the monthly Quality Assurance meeting and the plan of action adjusted accordingly, as warranted. **How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be monitored using the *Washington Nursing Center E036-20220817 Audit Tool*. Progress will be monitored 5 days a week for 1 month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or designee will review the audit tool(s) daily during Stand Up, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion.	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program			

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	§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. (iii) Provide emergency preparedness training			

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	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 services under arrangement, contractors,			

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	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. (iv) Demonstrate staff knowledge of			

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	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 procedures to all new and existing staff,			

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	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 review of the Emergency Preparedness Plan (EPP) on 08/17/22 between 9:00 a.m. and 12:00 p.m. with the Administrator and Maintenance Supervisor present, no documentation of annual EPP 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 record review, the Administrator confirmed there was no documentation of annual EPP training and no documentation to show staff could demonstrate knowledge of the EPP was available for review. This finding was reviewed with the Administrator	E 0037	Deficiency ID: E 037 *_What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?_ It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. The documentation in the EPP for annual facility training and testing program has been reviewed and updated. Staff in-service scheduled for 09/08/2022. *_How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?_ Washington Nursing Center will continue to review the Emergency Preparedness Binder at least monthly and updated revisions will be noted as needed.	09/09/2022

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	and Maintenance Supervisor during the exit conference.		*_What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?_ To ensure ongoing compliance, Washington Nursing Center will continue to review the Emergency Preparedness Binder and updated revisions will be noted at least monthly and as needed. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or the designee will be responsible for monitoring this POC to ensure its successful completion. This will be reviewed as part of the monthly Quality Assurance meeting and the plan of action adjusted accordingly, as warranted. *_How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?_ Progress toward the successful completion of this POC will be monitored using the _Washington Nursing Center E037-20220817 Audit Tool_. Progress will be monitored 5 days a week for 1 month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. Documentation of all activities associated with this POC will be	

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			noted on said audit tool. The Administrator and/or designee will review the audit tool(s) daily during Stand Up, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion.	
E 0039 SS=C 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			

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	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 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			

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	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 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:			

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	(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. (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			

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	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 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			

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	(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 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			

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	155145	A. BUILDING -- B. WING	08/17/2022

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	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. *[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			

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	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 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			

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	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 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.			

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	(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 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	E 0039	Deficiency ID: E 039 *_What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?_ It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. The documentation of tabletop exercises has been reviewed, documented, and added to the EPP. *_How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?_ Washington Nursing Center will continue to review the Emergency Preparedness Binder at least monthly and updated revisions will be noted as needed. *_What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?_ To ensure ongoing	09/09/2022

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	in the facility. Findings include: Based on review of the Emergency Preparedness Plan (EPP) on 08/17/22 between 9:00 a.m. and 12:00 p.m. with the Administrator and Maintenance Supervisor present, the facility was able to provide documentation of a community based exercise during the past 12 months, however, the facility was unable to provide documentation of a second exercise conducted during the past twelve months. The Administrator said the facility has taken part in a community based exercise during the past 12 months (COVID protocol and issues), and also a table top exercise based on the facility's emergency preparedness plan, but the table top exercise was not documented and therefore was not available. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.		compliance, Washington Nursing Center will continue to review the Emergency Preparedness Binder and updated revisions will be noted at least monthly and as needed. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or the designee will be responsible for monitoring this POC to ensure its successful completion. This will be reviewed as part of the monthly Quality Assurance meeting and the plan of action adjusted accordingly, as warranted. **How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be monitored using the *Washington Nursing Center E039-20220817 Audit Tool*. Progress will be monitored 5 days a week for 1 month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or designee will review the audit tool(s) daily during Stand Up, in accordance with the proposed schedule AND monthly during QAPI Committee meetings.	

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			The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system			

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	inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.			

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	(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). 1. 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 7 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,	E 0041	Deficiency ID: E 041 *_What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?_ It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. Generator testing and compliance are a part of the Washington Nursing Center	09/09/2022

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	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 weekly generator inspection reports on 08/17/22 between 9:00 a.m. and 12:00 p.m. with the Maintenance Supervisor present, there was no documentation available to show that the emergency generator was inspected/tested weekly during 7 of the most recent 52 week period, which included 7 of the past 8 weeks. Based on interview at the time of record review, the Maintenance Supervisor said the generator was inspected/tested weekly during 7 of the past 8 weeks, but it was not documented. This finding was reviewed with the Administraator and Maintenance Supervisor during the exit conference. 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 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		Preventive Maintenance (PM) program. Required monthly load testing of the emergency generator will be done in accordance with Life Safety code. Required weekly inspections of the emergency generator will be done in accordance with Life Safety code. Documentation of BOTH the weekly and monthly testing and inspections will be maintained in accordance with Life Safety code. *How will other residents having the potential to be affected by the same alleged deficient practice be identified and what Corrective action (s) will be taken? Generator testing and compliance is a part of the Washington Nursing Center Preventive Maintenance (PM) program. Required monthly load testing of the emergency generator will be done in accordance with Life Safety code. Required weekly inspections of the emergency generator will be done in accordance with Life Safety code. Documentation of BOTH the weekly and monthly testing and inspections will be maintained in accordance with Life Safety code. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not	

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	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. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 08/17/22 between 9:00 a.m. and 12:00 p.m. with the Maintenance Supervisor present, there was no documentation on the emergency generator monthly test form for percentage of load during the monthly load tests during the past 12 months. There was only the word "Good" in the percentage of load column. Based on interview at the time of record review, the Maintenance Supervisor agreed there was no documentation provided on the monthly generator load test form for percentage of load during the past 12 months. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3. Based on record review and interview the facility failed to ensure there was current documentation available that 1 of 1 emergency generator had a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 Edition, 5.1. LSC section 9.1.3.1 states emergency generators shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric		*recur?* Generator testing and compliance is a part of the Washington Nursing Center Preventive Maintenance (PM) program. Required monthly load testing of the emergency generator will be done in accordance with Life Safety code. Required weekly inspections of the emergency generator will be done in accordance with Life Safety code. Documentation of BOTH the weekly and monthly testing and inspections will be maintained in accordance with Life Safety code. Where there are changes in personnel, Washington Nursing Center will ensure transitional Requirements are maintained in accordance with Life Safety code. Documentation of such will be completed and maintained in accordance with Life Safety code. All activities related to this POC are part of the Washington Nursing Center Preventive Maintenance program and building rounding program. Facility Maintenance Director has been in-serviced on the above issue and compliance **How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be	

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	pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. A.5.1.1 states examples of probability of interruption could include the following: earthquake, flood damage, or a demonstrated utility unreliability. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 08/17/22 between 9:00 a.m. and 12:00 p.m. with the Maintenance Supervisor present, while reviewing the generator information it was determined the fuel source for the emergency generator was natural gas only. Additionally, the facility did not have a letter available from their natural gas provider indicating the natural gas was from a reliable source. Based on interview at the time of record review, the Maintenance Supervisor said the gas company had changed names and ownership within the past couple of years and there was no letter of reliability available to review. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.		monitored using the *Washington Nursing Center E041/K918-20220817 Audit Tool*. Progress will be monitored 5 days a week for 1 month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or designee will review the audit tool(s) daily during Stand Up, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion.	
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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: 08/17/22 Facility Number: 000068 Provider Number: 155145 AIM Number: 100274980 At this Life Safety Code survey, Washington Nursing Center 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 and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 140 and had a census of 37 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 one detached wood framed shed with metal siding used for facility storage. Quality Review completed on 08/25/22	K 0000	The creation and submission of this Plan of Correction (POC) does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this *CMS-2567 Plan of Correction* be considered the *Letter of Credible Allegation of Compliance* and requests a desk review in lieu of a post-survey review on, or after 09/09/2022.	
K 0222 SS=F	NFPA 101 Egress Doors			

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	155145	A. BUILDING 01 B. WING	08/17/2022

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Bldg. 01	Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with			

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	7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 5 of 8 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect all residents staff and visitors needing to exit the facility. Findings include: Based on observations on 08/17/22 between 12:00 p.m. and 3:00 p.m. during a tour of the facility with	K 0222	Deficiency ID: K 222 *What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. The means of egress through 5 of the exit doors have been made accessible. Codes have been updated and posted close to	09/09/2022

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	the Maintenance Supervisor, the following was noted: a. The northeast exit door in the North unit was posted with the incorrect code to actuate the door release. The Maintenance Supervisor was able to open the door with the correct code. The door code was also posted on a piece of paper at the top of the door frame. b. The west exit door in the South 1 unit near rooms 49 and 52 was posted with the incorrect code to actuate the door release. The Maintenance Supervisor was unable to release the door because he did not know the correct code. He said no other staff person would know the code either. The magnetic lock at the top of the door did release when the fire alarm system was tested. c. The south exit door in the south Short Hall unit was posted with the incorrect code to actuate the door release. The Maintenance Supervisor was unable to release the door because he did not know the correct code. He said no other staff person would know the code either. The magnetic lock at the top of the door did release when the fire alarm system was tested. d. The north exit door in the South 2 unit near room 75 was posted with the incorrect code to actuate the door release. The Maintenance Supervisor was able to open the door with the correct code. The door code was also posted on a piece of paper at the top of the door frame. e. The code to open the north exit door in the Rehab unit was posted on a piece of paper at the top of the door frame. Based on interview at the time of each observation, the Maintenance Supervisor agreed the correct codes should be displayed close to the keypad at each listed exit door. These findings were reviewed with the		keypads. *_How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?_ Washington Nursing Center corrected the identified concerns and will ensure codes will be updated and tested frequently along with code access posted near keypad. *_What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?_ Washington Nursing Center corrected the identified concerns and will ensure codes will be updated and tested frequently along with code access posted near keypad. Moreover, activities related to this POC will be made part of the Washington Nursing Center Preventive Maintenance program and building rounding program. Facility Maintenance Director has been in-serviced on the above issue and compliance *_How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?_ Progress toward the successful completion of this POC will be	

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	Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		monitored using the *Washington Nursing Center K22-20220817 Audit Tool*. Progress will be monitored 5 days a week for 1 month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or designee will review the audit tool(s) daily during Stand Up, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of over 30 exit signs were continuously illuminated. This deficient practice could affect at least 10 residents, as well as staff and visitors. Findings include:	K 0293	Deficiency ID: K 293 **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*	09/09/2022

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	Based on observations on 08/17/22 between 12:00 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, the exit sign over the smoke barrier doors at the south end of the office corridor (near room 42) was not illuminated. Based on interview at the time of observation, the Maintenance Supervisor said he was not aware that the exit sign was not illuminated. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1.19(b)		It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. The exit sign over smoke barrier doors at the south end of the office corridor was replaced and ensured to be continuously illuminated. **How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?* Washington Nursing Center corrected the identified areas (see above) and will ensure exit signs are continuously illuminated in accordance with Life Safety code going forward. **What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Washington Nursing Center corrected the identified areas and will ensure exit signs are continuously illuminated in accordance with Life Safety code going forward. Moreover, activities related to this POC will be made part of the Washington Nursing Center Preventive Maintenance program and building rounding	

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			program. Facility Maintenance Director has been in-serviced on the above issue and compliance **How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be monitored using the *Washington Nursing Center K293-20220817Audit Tool*. Progress will be monitored on 5 days a week for 1month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or designee will review the audit tool(s) daily during Stand Up, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This			

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	information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review and interview, the facility failed to ensure documentation for the preventative maintenance of battery operated smoke alarms in all resident rooms was complete. NFPA 72 14.2.1.1.1 states to ensure operations integrity, the system shall have an inspection, testing, and maintenance program. NFPA 72 29.10 states fire-warning equipment shall be maintained and tested in accordance with manufacturer's published instructions and per the requirements of Chapter 14. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 08/17/22 between 9:00 a.m. and 12:00 p.m. with the Maintenance Supervisor present, there was documentation available that battery operated smoke alarms in all resident rooms were tested monthly, however, the documentation provided, titled "Battery Check Smoke Detectors" was just a blanketed statement that all resident room smoke alarms were tested. There was no itemized list of which room smoke alarms were tested and the results of each test. Based on interview at the time of record review, the Maintenance Supervisor confirmed there was no itemized list of each resident room smoke alarm. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0300	Deficiency ID: K 300 *_What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?_ It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. Smoke alarm testing and compliance are a part of the Washington Nursing Center Preventive Maintenance (PM) program. Required testing will be done in accordance with Life Safety code. Documentation of BOTH the monthly testing and battery changes will be maintained in accordance with Life Safety code. *_How will other residents having the potential to be affected by the same alleged deficient practice be identified and what Corrective action (s) will be taken?_ Resident room battery powered smoke alarm testing and compliance is a part of the Washington Nursing Center Preventive Maintenance (PM) program. Required testing	09/09/2022

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			will be done in accordance with Life Safety code. Documentation of BOTH the monthly testing and battery changes will be maintained in accordance with Life Safety code. All activities related to this POC are part of the Washington Nursing Center Preventive Maintenance program. Facility Maintenance Director and department heads have been in-serviced on the above issue and compliance * *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* To ensure ongoing compliance, the monitoring tool was updated to ensure the location of each battery-operated smoke detector was noted for each test. The facility Maintenance Director was educated on the necessary documentation. As a means of quality assurance, the facility Maintenance Director will continue to monitor the battery-operated smoke detectors and will denote the location of each detector on the monitoring tool as part of the facility preventative maintenance program. The logs will be reviewed as part of the monthly Quality Assurance meeting and the plan of action adjusted accordingly, as warranted.	

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			**How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be monitored using the *Washington Nursing Center K300-20220817 Audit Tool*. Progress will be monitored 5 days a week for 1 month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or designee will review the audit tool(s) daily during Stand Up, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in			

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	smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to maintain 1 of 1 kitchens in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011. NFPA 96, Section 12.1.2.4 states all deep-fat fryers shall be installed with at least a 16 inch space between the fryer and surface flames from adjacent cooking equipment. Section 12.1.2.5 states where a steel or tempered glass baffle plate is installed at a minimum 8 inch in height between the fryer and surface flames of the adjacent appliance, the requirement for a 16 inch space shall not apply. This deficient practice could affect all residents in the dining room/kitchen area. Findings include: Based on an observations on 08/17/22 between 12:00 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, the deep fat fryer was located within six inches of the gas burners on the commercial cooking stove and did not have a protective shield measuring at least eight inches in height between the two appliances. Based on interview at the observation, the Maintenance Supervisor agreed the deep fat fryer was to close to the stove.	K 0324	Deficiency ID: K 324 *_What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?_ It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. The deep fat fryer was moved 16 inches from the stove and open flame, an 8-inch tempered baffle was installed. *_How will other residents having the potential to be affected by the same alleged deficient practice be identified and what Corrective action (s) will be taken?_ Washington Nursing Center corrected the identified areas (see above) and will ensure on going	09/09/2022

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	Within a half hour after observation, kitchen staff said he moved the deep fat fryer at least 16 inches away from the stove and ordered a metal baffle. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		compliance as a part of the Washington Nursing Center Preventive Maintenance (PM) program * *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* To ensure ongoing compliance, a monitoring tool was updated to ensure compliance. Dietary Manager and Maintenance Director were in-serviced. As a means of quality assurance, the facility Maintenance Director will continue to monitor the fryer location and ensure baffle is intact. The logs will be reviewed as part of the monthly Quality Assurance meeting and the plan of action adjusted accordingly, as warranted. *How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be monitored using the *Washington Nursing Center K324-20220817 Audit Tool*. Progress will be monitored 5 days a week for 1 month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. Documentation of all activities associated with this POC will be	

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			noted on said audit tool. The Administrator and/or designee will review the audit tool(s) daily during Stand Up, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure only one type of sprinkler head, i.e. quick response or standard sprinklers were installed in 2 of 12 smoke compartments. NFPA 13, 2010 Edition, Installation of Sprinkler Systems,	K 0351	Deficiency ID: K 351 *What corrective action(s) will be	09/09/2022

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	Section 8.3.3.2 states where quick-response sprinklers are installed, all sprinklers within a compartment shall be quick-response unless otherwise permitted in Section 8.3.3.3 Section 8.3.3.4 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a compartmented space shall be changed. This deficient practice could affect residents, as well as staff and visitors while in the Conference Room. Findings include: Based on observations on 08/17/22 between 12:00 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted: a. The north, east-west short corridor had one quick response sprinkler head mixed with several standard response sprinkler heads, furthermore, the north dining room/lounge was open to the north, east west-short corridor and was equipped with four quick response sprinkler heads. b. The Conference Room had one quick response sprinkler head and one standard response sprinkler head. Based on an interview at the time of each observation, the Maintenance Supervisor acknowledged the mixture of different type sprinkler heads within the compartmented spaces. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		*accomplished for those residents found to have been affected by the alleged deficient practice?* It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. Sprinkler heads in the North Corridor, north dining/lounge area, and conference room have been reported to IEI for repair to meet requirements, all other sprinkler heads reviewed to ensure compliance with Life Safety Code. **How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?* Washington Nursing Center corrected the identified areas. Sprinkler heads in the North Corridor, north dining/lounge area, and conference room have been reported to IEI for repair in order meet requirements, all other sprinkler heads reviewed to ensure compliance with Life Safety Code going forward. **What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Washington Nursing Center	

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	155145	A. BUILDING 01 B. WING	08/17/2022

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			corrected the identified areas and will ensure Sprinkler heads will be properly installed in compliance with Life Safety Code Moreover, activities related to this POC will be made part of the Washington Nursing Center Preventive Maintenance program and building rounding program. Facility Maintenance Director has been in-serviced on the above issue and compliance **How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be monitored using the *Washington Nursing Center K351-20220817 Audit Tool*. Progress will be monitored 5 days a week for 1month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or designee will review the audit tool(s) daily during Stand Up, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion	

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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 1. Based on observation and interview, the facility failed to ensure sprinkler heads in 3 of 12 smoke compartments covered with corrosion or paint were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect at least 10 resident, as well as kitchen staff and visitors within the smoke compartments.	K 0353	Deficiency ID: K353 *_What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?_ It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. Sprinkler system gauge inspection was completed, Sprinklers with corrosion/grease/paint were	09/09/2022

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	Findings include: Based on observations on 08/17/22 between 12:00 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted: a. There were two sprinkler heads in the dishwashing room covered with corrosion. b. There were seven sprinkler heads in the kitchen covered with corrosion and grease. c. There was one sprinkler head in resident room 89 partially covered with paint. Based on interview at the time of each observation, the Maintenance Supervisor agreed the previously mentioned sprinkler heads were covered with corrosion, grease, and paint and should be replaced. He further said he was aware of the sprinkler heads with corrosion and grease in the kitchen because the facility's sprinkler vendor pointed it out during their most recent inspection. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the ceiling in 4 of 12 sprinklered smoke compartments was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect mostly staff, plus residents in the adjacent areas. Findings include: Based on observations on 08/17/22 between 12:00 p.m. and 3:00 p.m. during a tour of the facility with		cleaned or reported to be replaced, the hole in north corridor ceiling, sprinkler head by room 64, gap around pipe in kitchen, and gap in gas water heater pipe near room 44, laundry room gas water heater duct gap are being repaired/replaced. Records of maintenance and inspection will be kept up to date in accordance with Life Safety Code going forward. The above corrective measures will be completed on or 09/08/2022. *_How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?_ Washington Nursing Center corrected the identified areas and will ensure Sprinkler system gauges are inspected and documented weekly, sprinkler heads are observed and cleaned/replaced as needed, and any gaps closed leading into attic/ceiling in accordance with Life Safety Code *_What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?_ Washington Nursing Center corrected the identified areas and	

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	the Maintenance Supervisor, the following was noted: a. There was a three inch by four inch hole in the north corridor ceiling to the attic space outside the maintenance room. b. The sprinkler head in the South 2 corridor outside room 64 was pulled up into the recessed escutcheon and to one side which would not allow the sprinkler head to operate properly. c. In the kitchen between the two walk-in coolers a pipe protruded through the ceiling that had a half inch gap around the pipe that was not properly fire stopped. d. The Mechanical Room near resident room 44 there was a gas water heater that had a metal duct vent through the ceiling. There was a one to two and a half inch gap around the duct vent to the attic space that was not provided with a sleeve or properly fire stopped. e. In the Laundry room there was a gas water heater that had a metal duct vent through the ceiling. There was a one to two and a half inch gap around the duct vent to the attic space that was not provided with a sleeve or properly fire stopped. Based on interview at the time of each observation, the Maintenance Supervisor acknowledged the gaps to the attic space in each of the previously mentioned areas. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b) 3. Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25		will ensure Sprinkler system gauge inspection is completed, sprinkler heads are observed and cleaned/replaced as needed, and any gaps closed leading into attic/ceiling in accordance with Life Safety Code. Moreover, activities related to this POC will be made part of the Washington Nursing Center Preventive Maintenance program and building rounding program. Facility Maintenance Director has been in-serviced on the above issue and compliance **How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be monitored using the *Washington Nursing Center K353-20220817 Audit Tool*. Progress will be monitored on 5 days a week for 1month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or designee will review the audit tool(s) daily during Stand Up, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Administrator, or designee will	

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	for 2 of 2 dry sprinkler systems during the past 52 weeks. NFPA 25, Standard for the Inspection, Testing, 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 08/17/22 between 9:00 a.m. and 12:00 p.m. with the Maintenance Supervisor present, there was no documentation available to show the facility's sprinkler system gauges were inspected weekly during the past 52 weeks or prior, and sprinkler control valves monthly during the past 12 months or prior. Based on interview at the time of record review, the Maintenance Supervisor said he inspects the gauges and control valves regularly but was not aware he was supposed to document the results. Based on observations with the Maintenance Supervisor during a tour of the facility between 12:00 p.m. and 3:00 p.m. the facility had at least three pressure gauges at each of the two sprinkler risers. This finding was reviewed with the Administrator		be responsible for monitoring this POC to ensure its successful completion	

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	and Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0363 SS=B Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire			

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	resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors on South 2 would latch into its door frame. This deficient practice could affect up to 18 residents, staff and visitors on South 2. Findings include: Based on observations on 08/17/22 between 12:00 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, the South 2 Linen closet corridor door would not latch into the door frame because the latching mechanism was missing from the door handle. Based on interview at the time of observation, the Maintenance Supervisor said he was not aware the door handle was missing the latching mechanism. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0363	Deficiency ID: K363 *_What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?_ It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. Door latches were inspected, door latch to south 2 linen closet has been repaired/replaced. Records of maintenance and inspection will be kept up to date in accordance with Life Safety Code going forward. *_How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?_ Washington Nursing Center corrected the identified areas and will ensure door latches are inspected and repaired in accordance with Life Safety Code	09/09/2022

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			**What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Washington Nursing Center corrected the identified areas and will ensure door latches are inspected/repaired in accordance with Life Safety Code. Moreover, activities related to this POC will be made part of the Washington Nursing Center Preventive Maintenance program and building rounding program. Facility Maintenance Director has been in-serviced on the above issue and compliance **How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be monitored using the *Washington Nursing Center K363-20220817 Audit Tool*. Progress will be monitored on 5 days a week for 1month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or designee will	

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			review the audit tool(s) daily during Stand Up, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion	
K 0511 SS=F Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on record review and interview the facility failed to ensure there was current documentation available that 1 of 1 emergency generator had a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 Edition, 5.1. LSC section 9.1.3.1 states emergency generators shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site	K 0511	Deficiency ID: K511 *_What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?_ It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. The facility has spoken with current gas company and requested a letter of liability that is being processed and emailed to maintain compliance with Life Safety Code going forward.	09/09/2022

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	fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. A.5.1.1 states examples of probability of interruption could include the following: earthquake, flood damage, or a demonstrated utility unreliability. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 08/17/22 between 9:00 a.m. and 12:00 p.m. with the Maintenance Supervisor present, while reviewing the generator information it was determined the fuel source for the emergency generator was natural gas only. Additionally, the facility did not have a letter available from their natural gas provider indicating the natural gas was from a reliable source. Based on interview at the time of record review, the Maintenance Supervisor said the gas company had changed names and ownership within the past couple of years and there was no letter of reliability available to review. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		*How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?* Washington Nursing Center corrected the identified areas and will ensure facility receives letter of liability from gas company and will monitor for changes that need to be made or corrected going forward to maintain compliance with Life Safety Code. **What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Washington Nursing Center corrected the identified areas and will ensure documentation of reliable gas source from Gas Co in accordance with Life Safety Code. Moreover, activities related to this POC will be made part of the Washington Nursing Center Preventive Maintenance program and building rounding program. Facility Maintenance Director has been in-serviced on the above issue and compliance. *How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful	

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			completion of this POC will be monitored using the *Washington Nursing Center K511-20220817 Audit Tool*. Progress will be monitored 5 days a week for 1month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or designee will review the audit tool(s) daily during Stand Up, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to provide quarterly fire drill	K 0712	Deficiency ID: K712	09/09/2022

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	documentation for 1 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 08/17/22 between 9:00 a.m. and 12:00 p.m. with the Maintenance Supervisor present, the facility lacked fire drill documentation for the third shift (night) of the fourth quarter (October, November, and December) of 2021. Based on interview at the time of record review, the Maintenance Supervisor confirmed the lack of a fire drill report for the third shift of the fourth quarter of 2021. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 12 of 12 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 08/17/22 between 9:00 a.m. and 12:00 p.m. with the Maintenance Supervisor present, all 12 fire drill reports performed during the past 12 month period did not include documentation for the transmission of the alarm to the monitoring company. Based on interview at the time of record review, the Maintenance Supervisor acknowledged there was no information on all 12		*_What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?_ It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. The facility is conducting quarterly fire drills on each shift, documentation updated and included transmission of alarm to the monitoring company. Records of maintenance and inspection will be kept up to date in accordance with Life Safety Code going forward. *_How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?_ Washington Nursing Center corrected the identified areas and will ensure facility quarterly fire drills are conducted quarterly on each shift and documentation including transmission of alarm to the monitoring company has been added in accordance with Life Safety Code. *_What measures will be put into place and what systemic changes will be made to ensure that the_	

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	fire drill reports to verify that transmission of the alarm was received by the monitoring company. 3-1.19(b) 3. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 3 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drills on 08/17/22 between 9:00 a.m. and 12:00 p.m. with the Maintenance Supervisor present, three of four, second shift (evening) fire drills were performed between 7:00 p.m. and 7:05 p.m. The fourth fire drill performed during the second shift, dated 01/29/22, did not have a time of drill provided. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the times of the second shift fire drills were performed and agreed the times were not varied enough. 3.1-19(b) 4. Based on record review and interview, the facility failed to ensure 5 of 12 fire drills performed during the past 12 month period were performed during their designated shift time frame. This deficient practice could affect all residents in the facility. Findings include: Based on interview during record review on 08/17/22 between 9:00 a.m. and 12:00 p.m., when asked, the Maintenance Supervisor said the first shift fire drills are performed between 8:00 a.m. and		*alleged deficient practice does not recur?* Washington Nursing Center corrected the identified areas and will ensure facility fire drills are conducted quarterly on each shift in accordance with Life Safety Code. Moreover, activities related to this POC will be made part of the Washington Nursing Center Preventive Maintenance program and building rounding program. Facility Maintenance Director has been in-serviced on the above issue and compliance. **How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be monitored using the *Washington Nursing Center K712-20220817 Audit Tool*. Progress will be monitored 5 days a week for 1month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or designee will review the audit tool(s) daily during Stand Up, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Administrator, or designee will be responsible for monitoring this	

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	4:30 p.m., second shift between 4:30 p.m. and 12:00 a.m., and third shift between 12:00 a.m. and 8:00 a.m. The following was noted: a. Fire drills on 10/23/21 at 6:10 p.m. and 12/18/21 at 9:20 p.m. were both listed as first shift fire drills. b. Fire drills on 02/13/22 at 9:00 p.m., 04/13/22 at 7:10 p.m., and 08/13/22 at 9:00 p.m. were all listed as third shift fire drills. Based on interview at the time of record review, the dates and times of the previous fire drill reports were confirmed by the Maintenance Supervisor. These finding were reviewed with the Administrator and Maintenance Supervisor during the exit conference.		POC to ensure its successful completion	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored			

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	energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 1 generator was maintained for 7 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: Based on review of the weekly generator	K 0918	Deficiency ID: K918 *_What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?_ It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. Generator testing and compliance are a part of the Washington Nursing Center Preventive Maintenance (PM) program. Required monthly load testing of the emergency generator will be done in accordance with Life Safety code. Required weekly inspections of the emergency generator will be done in accordance with Life	09/09/2022

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	inspection reports on 08/17/22 between 9:00 a.m. and 12:00 p.m. with the Maintenance Supervisor present, there was no documentation available to show that the emergency generator was inspected/tested weekly during 7 of the most recent 52 week period, which included 7 of the past 8 weeks. Based on interview at the time of record review, the Maintenance Supervisor said the generator was inspected/tested weekly during 7 of the past 8 weeks, but it was not documented. This finding was reviewed with the Administraator and Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 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. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 08/17/22 between 9:00 a.m. and 12:00 p.m. with the Maintenance Supervisor present, there was no documentation on the emergency generator monthly test form for percentage of load during the monthly load tests		Safety code. Documentation of BOTH the weekly and monthly testing and inspections will be maintained in accordance with Life Safety code. *_How will other residents having the potential to be affected by the same alleged deficient practice be identified and what Corrective action (s) will be taken?_ Generator testing and compliance is a part of the Washington Nursing Center Preventive Maintenance (PM) program. Required monthly load testing of the emergency generator will be done in accordance with Life Safety code. Required weekly inspections of the emergency generator will be done in accordance with Life Safety code. Documentation of BOTH the weekly and monthly testing and inspections will be maintained in accordance with Life Safety code. *_What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?_ Generator testing and compliance is a part of the Washington Nursing Center Preventive Maintenance (PM) program. Required monthly load testing of the emergency generator will be done in accordance with Life Safety code. Required weekly	

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	during the past 12 months. There was only the word "Good" in the percentage of load column. Based on interview at the time of record review, the Maintenance Supervisor agreed there was no documentation provided on the monthly generator load test form for percentage of load during the past 12 months. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		inspections of the emergency generator will be done in accordance with Life Safety code. Documentation of BOTH the weekly and monthly testing and inspections will be maintained in accordance with Life Safety code. Documentation of such will be completed and maintained in accordance with Life Safety code. All activities related to this POC are part of the Washington Nursing Center Preventive Maintenance program and building rounding program. Facility Maintenance Director has been in-serviced on the above issue and compliance **How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be monitored using the *Washington Nursing Center E041/K918-20210628 Audit Tool*. Progress will be monitored 5 days a week for 1 month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or designee will review the audit tool(s) daily during Stand Up, in accordance with the	

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			proposed schedule AND monthly during QAPI Committee meetings. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion.	