STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155606	A. BUILDING -- B. WING	01/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTSIDE RETIREMENT VILLAGE	8616 W 10TH ST INDIANAPOLIS, IN 46234

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/02/24 Facility Number: 000497 Provider Number: 155606 AIM Number: 100291530 At this Emergency Preparedness survey, Westside Retirement Village was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 132 certified beds. At the time of the survey, the census was 94. Quality Review completed on 01/05/24 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review, observation 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). This deficient practice could affect all residents, staff and visitors.	E 0041	E041 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **The monthly generator load test, and weekly generator inspections has been completed. The annual fuel**	01/19/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sherice Ricks	executive director	01/19/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Findings include: a. Based on review of Direct Supply TELS Logbook Documentation: "Test generator under load" documentation for the most recent twelve month period with the Executive Director, the Maintenance Director and the visiting Maintenance Director during record review from 8:55 a.m. to 1:05 p.m. on 01/02/24, monthly load testing documentation for December 2023 was not available for review. Based on interview at the time of record review, the visiting Maintenance Director agreed monthly load testing documentation for December 2023 was not available for review. b. Based on review of Direct Supply TELS Logbook Documentation: "Exercise generator (with no load)" documentation for the most recent twelve month period with the Executive Director, the Maintenance Director and the visiting Maintenance Director during record review from 8:55 a.m. to 1:05 p.m. on 01/02/24, weekly emergency generator inspection documentation after 08/23/23 was not available for review. Based on interview at the time of the exit conference, the visiting Maintenance Director stated he could only find one other weekly generator inspection after 08/23/23 which was documented as occurring on 12/09/23. c. Based on record review with the Executive Director, the Maintenance Director and the visiting Maintenance Director from 8:55 a.m. to 1:05 p.m. on 01/02/24, annual fuel quality testing documentation was not available for review. Based on interview during the exit conference from 3:40 p.m. to 4:50 p.m. on 01/02/23, the visiting Maintenance Director provided the emergency generator testing contractor's "Fuel Analysis		**analysis has been completed.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **This alleged deficient practice could affect all residents, staff and visitors. No residents, staff or visitors was affected.** **Maintenance director was provided reeducation on the requirements for maintaining facility generator and documentation.** What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **The Administrator /designee will be responsible to review weekly x 4, monthly x 3 months that the weekly generator inspection documentation, the monthly load document and the annual fuel testing analysis for completion and uploaded into the TELS system.** How the corrective action(s) will be monitored to ensure the deficient	

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	Report" documentation dated 12/08/23 which listed the results of annual fuel testing as "Fail". Based on interview at the time of the exit conference, the visiting Maintenance Director agreed additional diesel fuel testing and analysis documentation on or after 12/08/23 was not available for review. Based on observations with the Executive Director, the Maintenance Director and the visiting Maintenance Director during a tour of the facility from 1:30 p.m. to 3:40 p.m. on 01/02/24, the diesel fired emergency generator for the facility located outside the building had an affixed nameplate indicating the generator was rated at 400 kW. These findings were reviewed with the Executive Director and the visiting Maintenance Director during the exit conference.		practice will not recur, i.e., what quality assurance program will be put into place; **The results of these will be reviewed and discussed at the monthly facility QAPI for a total of 6 months. Frequency and duration of review will be increased as needed if any areas of noncompliance are identified during the auditing process. Administrator is responsible in ensuring compliance in this plan of correction.** By what date the systemic changes for each deficiency will be completed **January 19, 2024.**	
K 0000 Bldg. 03	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: 01/02/24 Facility Number: 000497 Provider Number: 155606 AIM Number: 100291530 At this Life Safety Code survey, Westside Retirement Village 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	K 0000		

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	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 II (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 132 and had a census of 94 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas which provide facility services were sprinklered. Quality Review completed on 01/05/24			
K 0300 SS=F Bldg. 03	NFPA 101 Protection - Other Based on record review, observation and interview; the facility failed to ensure documentation for the preventative maintenance of smoke detectors in all resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, 29.10 Maintenance and Tests states fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors.	K 0300	K 300 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **All battery operated smoke detectors in resident rooms has been tested and documented.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **This alleged deficient practice could affect all residents, staff**	01/19/2024

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	Findings include: Based on review of Direct Supply TELS Logbook Documentation: "Test all battery operated smoke detectors in resident rooms per manufacturer's recommendations" documentation for the most recent twelve month period with the Executive Director, the Maintenance Director and the visiting Maintenance Director during record review from 8:55 a.m. to 1:05 p.m. on 01/02/24, resident sleeping room smoke detector testing documentation after 07/27/23 was not available for review. Based on interview at the time of record review, the Maintenance Director and the visiting Maintenance Director agreed resident sleeping room smoke detector testing documentation after 07/27/23 was not available for review. Based on observations with the Executive Director, the Maintenance Director and the visiting Maintenance Director during a tour of the facility from 1:30 p.m. to 3:40 p.m. on 01/02/24, manufacturer's documentation affixed to the Kidde Model P3010K-CO smoke detector installed on the ceiling in resident sleeping Room 111 stated the unit was manufactured 07/21/22. The manufacturer's specifications affixed to the smoke detector did not state testing and cleaning frequency. Based on interview at the time of the observations, the Executive Director stated all resident sleeping rooms have the same model smoke detector installed in the room following the 10/05/22 Life Safety Code survey. These findings were reviewed with the Executive Director and the visiting Maintenance Director during the exit conference. Based on an Internet review of the manufacturer's specifications for the Kidde Model P3010K-CO		**and visitors. No residents, staff or visitors was affected.** **Maintenance director was provided reeducation regarding fire-warning equipment maintenance and testing in accordance with the manufacturer's requirements.** What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **The Administrator /designee will be responsible to review monthly x 6 months to ensure that resident's room smoke detector testing has been completed and the documentation has been uploaded into the TELS system.** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; **The results of these will be reviewed and discussed at the monthly facility QAPI for a total of 6 months. Frequency and duration of review will be increased as needed if any areas of noncompliance are identified during the auditing process. Administrator is**	

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	smoke alarm at 1:00 p.m. on 01/04/24, manufacturer's specifications stated to test the alarm weekly and to clean the alarm annually. 3.1-19(b)		**responsible in ensuring compliance in this plan of correction.** By what date the systemic changes for each deficiency will be completed **January 19, 2024.**	
K 0345 SS=F Bldg. 03	NFPA 101 Fire Alarm System - Testing and Maintenance Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. Section 12.2.4.4 requires all fire alarm systems shall test free of grounds. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Executive Director, the Maintenance Director and the visiting Maintenance Director during a tour of the facility from 1:30 p.m. to 3:40 p.m. on 01/02/24, the display for the facility's main fire alarm panel and remote fire panel's at two of the facility's nurses station indicated a "Ground Fault" and was in the trouble mode. Based on interview at the time of the observations, the Maintenance Director stated the fire alarm system could be activated but agreed the fire alarm system for the facility was	K 0345	K345 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **The fire alarm system is no longer in trouble mode and is free of grounds.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**;** **This alleged deficient practice could affect all residents, staff and visitors. No residents, staff or visitors was affected.** **Maintenance director was provided reeducation regarding fire -warning equipment maintenance in accordance with the**	01/19/2024

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	currently in the trouble mode. These findings were reviewed with the Executive Director and the visiting Maintenance Director during the exit conference. 3.1-19(b)		**manufacturer's requirements.** What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **The Administrator /designee will be responsible to review weekly x 4, monthly x 3 months to ensure that resident's room smoke detector testing has been completed and the documentation has been uploaded into the TELS system.** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; **The results of these will be reviewed and discussed at the monthly facility QAPI for a total of 6 months. Frequency and duration of review will be increased as needed if any areas of noncompliance are identified during the auditing process. Administrator is responsible in ensuring compliance in this plan of correction.** By what date the systemic	

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			changes for each deficiency will be completed **January 19, 2024.**	
K 0353 SS=F Bldg. 03	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. 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. Findings include: Based on review of Direct Supply TELS Logbook Documentation: "Fire Sprinkler System: Fire Sprinkler Gauges" and "Fire Sprinkler System: Inspect fire sprinkler control valves"	K 0353	K353 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **The sprinkler system gauge and valve inspection has been completed and documented.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **This alleged deficient practice could affect all residents, staff and visitors. No residents, staff or visitors was affected.** **Maintenance director was provided reeducation regarding fire equipment maintenance and inspection.**	01/19/2024

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	documentation for the most recent twelve month period with the Executive Director, the Maintenance Director and the visiting Maintenance Director during record review from 8:55 a.m. to 1:05 p.m. on 01/02/24, monthly sprinkler system gauge and valve inspection documentation after 10/07/23 was not available for review. Based on interview at the time of record review, the visiting Maintenance Director agreed monthly sprinkler system gauge and valve inspection documentation after 10/07/23 was not available for review. Based on observations with the Executive Director, the Maintenance Director and the visiting Maintenance Director during a tour of the facility from 1:30 p.m. to 3:40 p.m. on 01/02/24, the sprinkler system inspection contractor had affixed a hanging tag to the facility's supervised wet sprinkler system riser room documenting additional monthly sprinkler system gauge and valve inspections were conducted by the contractor in November 2023. These findings were reviewed with the Executive Director and the visiting Maintenance Director during the exit conference. 3.1-19(b)		What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **The Administrator /designee will be responsible to review monthly x 6 months that the sprinkler system gauge and valve inspection daily monthly to ensure that resident's room smoke detector testing has been completed and the documentation has been uploaded into the TELS system.** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; **The results of these will be reviewed and discussed at the monthly facility QAPI for a total of 6 months. Frequency and duration of review will be increased as needed if any areas of noncompliance are identified during the auditing process. Administrator is responsible in ensuring compliance in this plan of correction.** By what date the systemic	

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			changes for each deficiency will be completed **January 19, 2024.**	
K 0355 SS=E Bldg. 03	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to ensure 7 of 35 portable fire extinguishers were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect over 40 residents, staff and visitors. Findings include: Based on observations with the Executive Director, the Maintenance Director and the visiting Maintenance Director during a tour of the	K 0355	K355 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **All portable fire extinguishers were inspected and documented.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **This alleged deficient practice could affect over 40 resident, staff and visitors. No residents, staff or visitors was affected.** **Maintenance director was provided reeducation regarding fire equipment maintenance and inspection.** What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	01/19/2024

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	facility from 1:30 p.m. to 3:40 p.m. on 01/02/24, the affixed maintenance tag for the following ABC type portable fire extinguisher locations had missing monthly inspection documentation: a. in the soiled side of the Laundry room for November and December 2023. b. in the Alzheimer's wing nurse's station for October and December 2023. c. in the corridor outside Room 119 for December 2023. d. in the 300 Hall nurse's station by the Med Room for August and September 2023. e. in the Central Supply Room for November and December 2023. f. in the corridor by Room 105 for November and December 2023. g. in the Maintenance Office for the eight month period of May 2023 through December 2023. The portable fire extinguisher inspection contractor indicated on the affixed maintenance tag the annual inspection and maintenance for each of the seven fire extinguishers was performed in January 2023. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned portable fire extinguisher locations each had missing monthly inspection documentation. These findings were reviewed with the Executive Director and the visiting Maintenance Director during the exit conference. 3.1-19(b)		**The Administrator /designee will be responsible to review monthly x 6 months that portable fire extinguisher inspections has been has been completed and the documentation has been uploaded into the TELS system.** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; weekly **The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached.** By what date the systemic changes for each deficiency will be completed **January 19, 2024.**	

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K 0911 SS=F Bldg. 03	NFPA 101 Electrical Systems - Other Based on observation and interview, the facility failed to ensure access and working space was maintained in enclosures housing electrical apparatus in 1 of 2 maintenance office electrical rooms. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2) and (3). Distances shall be measured from the live parts if such parts are exposed or from the enclosure front or opening if such are enclosed. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Executive Director, the Maintenance Director and the visiting Maintenance Director during a tour of the facility from 1:30 p.m. to 3:40 p.m. on 01/02/24, combustible boxes were stored up against all electrical panels in the maintenance office storage room including the electrical panel identified as "DP-1" which was on the emergency generator. Based on interview at the time of the observations, the visiting Maintenance Director agreed combustible boxes were stored within three feet of the working space in front of all the	K 0911	K911 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Items in maintenance office store within three feet of electrical panels were removed.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **This alleged deficient practice could affect all residents, staff and visitors. No residents, staff or visitors was affected.** **Maintenance director was provided reeducation in regards to maintaining a three feet clearance of items away from electrical panels.** What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	01/19/2024

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	155606	A. BUILDING 03 B. WING	01/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTSIDE RETIREMENT VILLAGE	8616 W 10TH ST INDIANAPOLIS, IN 46234

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	electrical panels in the maintenance office storage room. These findings were reviewed with the Executive Director and the visiting Maintenance Director during the exit conference. 3.1-19(b)		**The Administrator /designee will be responsible to monitor weekly x 4, monthly x 3 months to ensure items are not placed within three feet of electrical panel in maintenance office.** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; **The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached.** By what date the systemic changes for each deficiency will be completed **January 19, 2024.**	

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K 0918 SS=F Bldg. 03	NFPA 101 Electrical Systems - Essential Electric Syste 1. Based on record review, observation and interview; the facility failed to document emergency generator monthly load testing for 1 month of the most recent 12 month period to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation: "Test generator under load" documentation for the most recent twelve month period with the Executive Director, the	K 0918	K918 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **The monthly generator load test, and weekly generator inspection has been completed. Annual fuel analysis has been completed.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **This alleged deficient practice could affect all residents, staff and visitors. No residents, staff or visitors was affected.** **Maintenance director was provided reeducation on the requirements for maintaining facility generator and documentation.** What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	01/19/2024

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	Maintenance Director and the visiting Maintenance Director during record review from 8:55 a.m. to 1:05 p.m. on 01/02/24, monthly load testing documentation for December 2023 was not available for review. Based on interview at the time of record review, the visiting Maintenance Director agreed monthly load testing documentation for December 2023 was not available for review. Based on observations with the Executive Director, the Maintenance Director and the visiting Maintenance Director during a tour of the facility from 1:30 p.m. to 3:40 p.m. on 01/02/24, the diesel fired emergency generator for the facility located outside the building had an affixed nameplate indicating the generator was rated at 400 kW. These findings were reviewed with the Executive Director and the visiting Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the facility's emergency generator was maintained for 17 weeks of the most recent 52 week period. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 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.		**The Administrator /designee will be responsible to review weekly x 4, monthly x 3 months the generator inspection documentation, the monthly load document and the annual fuel testing analysis for completion.** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; **The results of these will be review and discussed at the monthly facility QAPI for a total of 6 months. Frequency and duration of review will be increased as needed if any areas of noncompliance are identified during the auditing process. Administrator is responsible in ensuring compliance in this plan of correction.** By what date the systemic changes for each deficiency will be completed **January 19, 2024.**	

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	Findings include: Based on review of Direct Supply TELS Logbook Documentation: "Exercise generator (with no load)" documentation for the most recent twelve month period with the Executive Director, the Maintenance Director and the visiting Maintenance Director during record review from 8:55 a.m. to 1:05 p.m. on 01/02/24, weekly emergency generator inspection documentation after 08/23/23 was not available for review. Based on interview at the time of the exit conference, the visiting Maintenance Director stated he could only find one other weekly generator inspection after 08/23/23 which was documented as occurring on 12/09/23. These findings were reviewed with the Executive Director and the visiting Maintenance Director during the exit conference. 3.1-19(b) 3. Based on record review, observation and interview; the facility failed to ensure the annual fuel quality test performed for the facility's diesel powered generator passed testing. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents, staff and visitors.			

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	Findings include: Based on record review with the Executive Director, the Maintenance Director and the visiting Maintenance Director from 8:55 a.m. to 1:05 p.m. on 01/02/24, annual fuel quality testing documentation was not available for review. Based on observations with the Executive Director, the Maintenance Director and the visiting Maintenance Director during a tour of the facility from 1:30 p.m. to 3:40 p.m. on 01/02/24, the diesel fired emergency generator for the facility located outside the building had an affixed nameplate indicating the generator was rated at 400 kW. Based on interview during the exit conference from 3:40 p.m. to 4:50 p.m. on 01/02/23, the visiting Maintenance Director provided the emergency generator testing contractor's "Fuel Analysis Report" documentation dated 12/08/23 which listed the results of annual fuel testing as "Fail". Based on interview at the time of the exit conference, the visiting Maintenance Director agreed additional diesel fuel testing and analysis documentation on or after 12/08/23 was not available for review. These findings were reviewed with the Executive Director and the visiting Maintenance Director during the exit conference. 3.1-19(b)			