STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING -- B. WING	08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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: 08/03/21 Facility Number: 000316 Provider Number: 155491 AIM Number: 100286370 At this Emergency Preparedness survey, Majestic Care of Connersville was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 166 certified beds. At the time of the survey, the census was 86. Quality Review completed on 08/09/21	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/03/21 Facility Number: 000316 Provider Number: 155491 AIM Number: 100286370	K 0000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 01 B. WING	08/03/2021

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	At this Life Safety Code survey, Majestic Care of Connersville 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. The facility consisted of two, one story buildings, the East Building (2) and the West Building (1), which were determined to be of Type V (111) construction and the West Building is fully sprinkled. Each building has a fire alarm system with smoke detection in the corridors and spaces open to the corridor. The facility has a capacity of 166 and had a census of 86 at the time of this survey. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinklered. Quality Review completed on 08/09/21			
K 0712 SS=C 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.			

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	19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors in building 1. Findings include: Based on records review of the "Fire Drills" and interview with the Executive Director on 08/03/21 between 11:00 a.m. and 1:30 p.m., 7 of 8 fire drills were conducted near the end of the month, on or near the 27th day of the month. The facility has 2 twelve-hour shifts (7-7). These conditions do not allow fire drills to be conducted at unexpected times. This finding was acknowledged by the Executive Director at the time of observation and again at the exit conference with the Executive Director on 08/03/21 at 5:15 p.m. 3.1-19(b)	K 0712	1. The allegation is that the facility failed to conduct fire drills on unexpected days at unexpected times. 2. No residents were effected, but all residents had the potential to be at risk by this deficient practice. 3. Education given that all fire drills will be given at unexpected days and times through out the month. 4. To ensure compliance the Maintenance person or designee will be responsible to complete the QA monitoring tool weekly for 4 weeks, then monthly for 6 months.	08/27/2021
K 0325 SS=E Bldg. 02	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser			

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	per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485			
	Based on observation and interview, the facility failed to ensure 1 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1-inch horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1-inch horizontal distance from the ignition source (c) Beneath an ignition source within a 1-inch vertical distance from the ignition source This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation with the Executive Director on 08/03/21 during a facility tour between 1:30 p.m. and 4:45 p.m., an alcohol-based hand sanitizer dispenser was installed on the wall directly above an electrical outlet in the 400 hallway corridor by room 407.	K 0325	1. The allegation is that the facility allowed an alcohol-based hand sanitizer dispenser to be installed on the wall directly above an electrical outlet on the 400 hall. 2. No residents were effected, but all residents had the potential to be at risk by this deficient practice. 3. The alcohol-based sanitizer dispenser has been removed. Maintenance Director has been educated on proper placement of alcohol dispensers. 4. To ensure compliance the Maintenance person or designee will be responsible to complete the QA monitoring tool weekly for 4 weeks, then monthly for 6 months. Results of audit findings will be presented to QA committee.	08/27/2021

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	Based on interview at the time of observation, the Executive Director confirmed the alcohol-based hand sanitizer dispenser was installed on the wall directly above an electrical outlet in the corridor by room 407. This finding and measurement was acknowledged by the Executive Director at the time of facility tour and again at the exit conference with the Executive Director on 08/03/21 at 5:15 p.m. 3.1-19(b)			
K 0351 SS=C Bldg. 02	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 the installation of the sprinkler system met the requirements of NFPA 13. NFPA 13, Standard for the Installation of	K 0351	1. The allegation is the the facility failed to ensure the installation of the sprinkler system met the requirements of NFPA 13.	08/27/2021

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	Sprinkler Systems, 2010 Edition; Section 6.2.9.1 states a supply of at least six spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have operated or been damaged in any way can be promptly replaced. This deficient practice could affect all occupants within the facility. Findings include: Based on observation with the Executive Director on 08/03/21 during a facility tour between 1:30 p.m. and 4:45 p.m., the sprinkler riser room on the 100 Hall did not contain a spare sprinkler box that was identifiable or accessible. Based on interview at the time of observation, the Executive Director confirmed the sprinkler riser room did not contain a spare sprinkler box that was identifiable or accessible. This surveyor was unable to confirm if the room contained the required spare sprinkler box. This finding was acknowledged by the Executive Director at the time of facility tour and again at the exit conference with the Executive Director on 08/03/21 at 5:15 p.m. 3.1-19(b)		2. No residents were effected, but all residents had the potential to be at risk by this deficient practice. 3. The Maintenance person placed the required spare sprinkler box in an accessible area. 4. To ensure compliance the Administrator or designee will be responsible to complete the QA monitoring tool weekly for 4 weeks and then monthly for 6 months.	
K 0355 SS=E Bldg. 02	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 2 portable fire extinguishers in the 300 were installed in accordance with	K 0355	1' The allegation is that the facility failed to ensure 1 of 2 portable fire extinguishers in the 300 hall	08/27/2021

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	NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect all staff and residents in the 300 Hall. Findings Include: Based on observation with the Executive Director on 08/03/21 during a facility tour between 1:30 p.m. and 4:45 p.m., the Fire Extinguisher wall mounted box in the 300 Hall near the exit door did not contain a fire extinguisher. The Executive Director stated they removed the extinguisher understanding they had already met the required number. The empty Fire Extinguisher wall mounted box would falsely lead someone into believing there was extinguishing equipment located there in the event of a fire. The Executive Director stated they would either provide the extinguisher or remove the box. This finding was acknowledged by the Executive Director at the time of facility tour and again at the exit conference with the Executive Director on 08/03/21 at 5:15 p.m. 3.1-19(b)		were installed in accordance with NFPA 10 standard for portable fire extinguishers. 2. No residents were effected, but all residents had the potential to be at risk by this deficient practice. 3. Fire extinguisher was placed in the mounted box on the 300 hall. Care team members educated that fire extinguishers are required to be mounted inside the wall in the fire extinguisher box. 4. To ensure compliance the Maintenance person or designee will be responsible to complete the QA monitoring tool weekly for 4 weeks, then monthly for 6 months.	
K 0211 SS=F	NFPA 101 Means of Egress - General			

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Bldg. 03	Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 2 of 4 corridor means of egresses in building 1 were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice affects all residents in the facility. Findings include: Based on observation with the Executive Director on 08/03/21 during a facility tour between 1:30 p.m. and 4:45 p.m., in the 800 resident hall three Personal Protective Equipment (PPE) carts were in use but were not equipped with wheels allowing the carts to be	K 0211	1. The allegation is that the facility failed to ensure 2 of 4 corridor means of egresses in building 1 were maintained free of obstruction. 2. No residents were effected, but all residents had the potential to be are risk by this deficient. 3. PPE carts have been removed from the hall and if PPE carts are needed again they will all have wheels on them. Care team members have been educated on keeping a clear egress. 4. To ensure compliance the Administrator or designee will be responsible to complete the QA monitoring tool weekly for 4 weeks, and monthly for 6 months.	08/27/2021

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	move out of the halls during an emergency. Based on an interview at the time of observations, the Executive Director stated the PPE carts are not equipped with wheels and would need to be replaced with PPE cart with wheels. This finding was acknowledged by the Executive Director at the time of facility tour and again at the exit conference with the Executive Director on 08/03/21 at 5:15 p.m. 3.1-19(b)			
K 0222 SS=E Bldg. 03	NFPA 101 Egress Doors 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			

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	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 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 1 of 1 delayed egress locking	K 0222	1. The allegation is that the facility failed to ensure delayed	08/27/2021

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	arrangements in the 600 hall was installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect 35 residents in the Walnut Grove hall and Chestnut hall Findings include: Based on observation with the Executive Director on 08/03/21 during a facility tour between 1:30 p.m. and 4:45 p.m., the 600 hall exit door was equipped with a 15 second delayed egress. When the exit doors were tested the irreversible process to release the lock was not initiated. Based on interview at the time of observation, the Surveyor and Executive Director tried 3 times to activate the delay egress. The Executive Director stated the delayed egress is not working and will need to be repaired. This finding was acknowledged by the Executive Director at the time of facility tour and again at the exit conference with the Executive Director on 08/03/21 at 5:15 p.m.		egress locking arrangements in the 600 hall 2. No residents were effected. 3, The 600 hall door was not set up as a 15 second egress door. Egress verbiage has been removed from the door. Maintenance Director has been educated on 15 second egress requirement. 4. To ensure compliance the Administrator or designee will be responsible to complete the QA monitoring tool weekly for 4 weeks, then monthly for 6 months. Results of findings will be presented to QA committee.	

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K 0232 SS=F Bldg. 03	3.1-19(b) NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation, the facility failed to meet the clear width requirement for 1 of 4 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by LSC 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in LSC 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with LSC 19.3.4, or the fixed furniture spaces	K 0232	1. The allegation is that the facility failed to maintain the width requirement for 1 of 4 corridors. 2. No residents were effected, but all residents had the potential to be at risk by this deficient practice. 3. The furniture has been removed from the 600 hall. Care team members have been educated on keeping a clear egress. 4. To ensure compliance the Administrator or designee will be responsible to complete the QA monitoring tool weekly for 4 weeks and monthly for 6 months. Results of audit findings will be presented to QA committee.	08/27/2021

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MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with LSC 19.3.5.8 This deficient practice could affect all residents, staff and visitors exiting the facilities main entrance or if needing to exit through the Service Hallway. Findings: 1. Based on observation with the Executive Director on 08/03/21 during a facility tour between 1:30 p.m. and 4:45 p.m., the main entrance corridor contained chairs extending into the corridor more than 24 inches. The aforementioned chairs were free standing, not affixed to the wall or floor. This finding and measurement was acknowledged by the Executive Director at the time of facility tour and again at the exit conference with the Executive Director on 08/03/21 at 5:15 p.m. 2. Based on observation with the Executive Director on 08/03/21 during a facility tour between 1:30 p.m. and 4:45 p.m., the 600 hall corridor contained chairs extending into the corridor more than 24 inches. The aforementioned chairs were free standing, not affixed to the wall or floor. This finding and measurement was acknowledged by the Executive Director at the time of facility tour and again at the exit conference with the Executive Director on 08/03/21 at 5:15 p.m. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 03 B. WING	08/03/2021

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K 0293 SS=E Bldg. 03	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 1 doors to the outside of the facility in the dining hall were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 20 residents, staff and visitors. Findings include: Based on observation with the Executive Director on 08/03/21 during a facility tour between 1:30 p.m. and 4:45 p.m., the 200 Hall dining room door to the courtyard was not posted with a NO EXIT sign. The exit gate from the courtyard, near the generator, was chain locked in the closed position. The Executive Director stated they are adding a sidewalk from the courtyard to the public way and have the gate locked until such time. Based on interview at the time of the observations, the Executive Director	K 0293	1.The allegation is that the facility failed to ensure 1 of 1 doors to the outside of the facility in the dining hall were not mistaken as a facility exit. 2. No residents were effected, but all residents had the pot5ential to be at risk by this deficient practice. 3. Correct verbiage, NO EXIT sign has been placed on the dining room door. 4, To ensure compliance the Administrator or designee will be responsible to complete the QA monitoring tool weekly for 4 weeks, the monthly for 6 months. Results of audit fin dings will be presented to QA committee.	08/27/2021

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	stated each door to the courtyard is not an exit to the public way and acknowledged the aforementioned door to the courtyard did not have a NO EXIT sign posted. This finding was acknowledged by the Executive Director at the time of facility tour and again at the exit conference with the Executive Director on 08/03/21 at 5:15 p.m. 3.1-19(b)			
K 0321 SS=E Bldg. 03	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons)			

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	e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure the corridor door to 2 of over 10 hazardous areas, such as storage rooms of combustible supplies over 50 square feet in size, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect over 30 residents in the 800 and 300 Hall plus any number of staff and visitors while in the corridors. Findings include: 1. Based on observation with the Executive Director on 08/03/21 during a facility tour between 1:30 p.m. and 4:45 p.m., the corridor door to the 800 Hall overflow storage room, being used for storage of cardboard boxes containing supplies and paper goods, lacked a self-closing mechanism. The lack of a self-closing door device was acknowledged by the Executive Director at the time of observation. 2. Based on observation with the Executive Director on 08/03/21 during a facility tour between 1:30 p.m. and 4:45 p.m., resident room 301, greater than 50 square feet, is now being used as storage of combustible/flammable material such as paper and cardboard. The aforementioned room corridor door was not equipped with a self-closing device. 3. These findings were acknowledged by the Executive Director at the time of facility tour	K 0321	1. The allegation is that the facility failed to have a self-closing mechanism to storage room on the 800 hall and room 301. 2. No residents were effected, but all residents had the potential to be at risk by this deficient practice. 3. Self Closing door devices have been added to both room 301 and 800 hall storage room. 4. To ensure compliance the Administrator or designee will be responsible to complete the QA monitoring tool weekly for 4 weeks, then monthly for 6 months. Results of the audit findings will be presented to QA committee.	08/27/2021

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	and again at the exit conference with the Executive Director on 08/03/21 at 5:15 p.m. 3.1-19(b)			
K 0324 SS=E Bldg. 03	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 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 ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchen. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect staff in the kitchen and 25 residents in the dining room.	K 0324	1. The allegation is that the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchen. and that the staff was unsure of what extinguisher to use in case of grease fire. 2. No residents were effected, but all residents had the potential to be at risk by this deficient	08/27/2021

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	Findings include: Based on observation with the Executive Director on 08/03/21 during a facility tour between 1:30 p.m. and 4:45 p.m., the kitchen in the West building contained a UL 300 hood system and a K-class fire extinguisher with posted instructions. Based on interview, the two ladies at the appliance were asked; what is the correct response if there was a grease fire underneath the hood. The employees replied, "Grab an extinguisher." When asked, "do you know where your hood suppression pull station is located?" The employees failed to identify the location of either the pull station or the K Class extinguisher. The employees failed to indicate activating the UL 300 hood extinguishing system and using the correct fire extinguisher for a hood grease fire. The Executive Director acknowledged the responses and stated additional training would be necessary. This finding was acknowledged by the Executive Director at the time of facility tour and again at the exit conference with the Executive Director on 08/03/21 at 5:15 p.m. 3.1-19(b)		practice. 3. Staff has been educated and in-serviced on how to use the pull station and the K Class extinguisher. 4. To ensure compliance the Administrator or designee will be responsible to in-service new staff and do annual in-servicing on proper use of Pull station and how to use the K Class extinguisher.	
K 0353 SS=E Bldg. 03	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.			

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	a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure sprinkler heads in several locations were not loaded or covered with foreign material in accordance with LSC 9.7.5. 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 staff and up to 20 residents and visitors at the entrance. Findings include: Based on observation with the Executive Director on 08/03/21 during a facility tour between 1:30 p.m. and 4:45 p.m., sprinkler heads in the following locations were coved in dust or showed signs of loading. (A) The kitchen Walk-In cooler. (B) Near the Dishwasher in the kitchen. (C) In the dietary supervisor's office. (D) Over the Candy vending machine in the	K 0353	1. The allegation is that the facility failed to ensure sprinkler heads in several locations were not loaded or covered with foreign material. 2. No residents were effected, but all residents had the potential to be at risk by this deficient practice. 3. All sprinkler heads in the building have been cleaned including the Walk in Cooler, Near the dishwasher in the kitchen, in the dietary supervisor's office and over the candy vending machines in the kitchen corridor. Maintenance Director has been educated on ensuring that sprinkler heads are free from debris. 4. To ensure compliance the Maintenance person or designee will be responsible to complete the QA monitoring tool weekly for 4 weeks, then monthly for 6 months. Results of audit findings will be presented to QA committee.	08/27/2021

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	kitchen corridor. These findings were acknowledged by the Executive Director at the time of facility tour and again at the exit conference with the Executive Director on 08/03/21 at 5:15 p.m. 3.1-19(b)			
K 0363 SS=E Bldg. 03	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,			

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	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 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. 1. Based on observation and interview, the facility failed to ensure 8 of over 70 doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect over 30 residents. Findings include: Based on observation with the Executive Director on 08/03/21 during a facility tour between 1:30 p.m. and 4:45 p.m., the following doors would not latch into the frame when tested. (A) Corridor door to resident room 809. (B) Corridor door to Shower Room in 600 Hall. (C) Corridor door to resident room 605. (D) Corridor door to resident room 610. (E) Corridor door to the Therapy Room in the East Building. (F) Corridor door to the Salon in the 100 Hall. (G) Mechanical Room access door in the shower room on the 100 Hall. This door sits at an angel due to the slope of the floor. The door rubbed the floor substantially and failed to self-close and latch. (H) Exit door from the kitchen service hall. (I) Corridor door to the Linen closet in the 700	K 0363	1. The allegation is that the facility failed to ensure 8 of over 70 doors failed to provide with a means suitable for keeping doors closed. 2. No residents were effected, but all residents had the potential to be at risk by this deficient practice. 3. All doors including the 8 effected were serviced by Safe Care to ensure proper closing. 4. To ensure compliance the Maintenance person or designee will be responsible to complete the QA monitoring tool weekly for 4 weeks, then monthly for 6 months.	08/27/2021

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	Hall. These findings was acknowledged by the Executive Director at the time of facility tour and again at the exit conference with the Executive Director on 08/03/21 at 5:15 p.m. 2. Based on observation and interview, the facility failed to ensure 2 of over 70 corridor doors would resist the passage of smoke. This deficient practice could affect 6 residents. Findings include: Based on observation with the Executive Director on 08/03/21 during a facility tour between 1:30 p.m. and 4:45 p.m., the following corridor doors had holes which penetrated completely through the door: A) The corridor door to the Housekeeping closet near the end of the 700 Hall. The door handle was extremely loose creating a ¼ inch hole/gap. B) Corridor door to the Shower Room on the 300 Hall was missing a handle leaving a 3.5 inch hole. This finding was acknowledged by the Executive Director at the time of facility tour and again at the exit conference with the Executive Director on 08/03/21 at 5:15 p.m. 3.1-19(b)			
K 0372 SS=E Bldg. 03	NFPA 101 Subdivision of Building Spaces - Smoke Barrie			

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	Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure unsealed holes in 1 of 1 ceiling smoke barriers were protected to maintain the smoke resistance of the ceiling smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff in the Maintenance Directors Storage room. Findings include:	K 0372	1. The allegation is that the facility failed to ensure unsealed holes in ceiling smoke barrier. 2. No residents were effected, but all residents had the potential to be at risk by this deficient practice. 3. 4 separate unsealed holes in Maintenance room ceiling fixed and sealed. 4. To ensure compliance the Maintenance person or designee will be responsible to complete the QA monitoring tool weekly for 4 weeks, the monthly for 6 months.	08/27/2021

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	1. Based on observation with the Executive Director on 08/03/21 during a facility tour between 1:30 p.m. and 4:45 p.m., the maintenance Directors storage office contained a 60-minute smoke barrier. In the ceiling tile there were four separate unsealed holes where tiles were broken and wire was penetrating. Based on interview at the time of observation, the Executive Director agreed there were four unsealed holes in the ceiling smoke barrier. 2. Based on observation with the Executive Director on 08/03/21 during a facility tour between 1:30 p.m. and 4:45 p.m., the sprinkler head near room 911 in the 900 hall corridor had a 1 inch gap around the escutcheon. These findings were acknowledged by the Executive Director at the time of facility tour and again at the exit conference with the Executive Director on 08/03/21 at 5:15 p.m. 3.1-19(b)			
K 0511 SS=E Bldg. 03	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 observation and interview, the facility failed to ensure all electrical panels in the corridors were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B).	K 0511	1. This allegation is that the facility failed to ensure all electrical panels were locked when tested. 2. No residents were effected, but all residents had the potential to be at risk by this deficient	08/27/2021

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	(A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect staff in the service hall. Findings include: Based on observation with the Executive Director on 08/03/21 during a facility tour between 1:30 p.m. and 4:45 p.m., three electrical panels in the 600 hall were unlocked when tested. Two electrical panels in the memory/dementia care 300 hall were not locked when tested. Based on interview at the time of observation, the Executive Director stated the electrical panel will need to be locked. These findings were acknowledged by the Executive Director at the time of facility tour and again at the exit conference with the Executive Director on 08/03/21 at 5:15 p.m. 3.1-19(b)		practice. 3. Audit of all electric panels done and all electrical panels are locked. Care team members educated that all electrical panels must be secured at all times. 4. To ensure compliance the Maintenance person or designee will be responsible to complete the QA monitoring tool weekly for 4 weeks, and then monthly for 6 months.	
K 0741 SS=E Bldg. 03	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable			

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	155491	A. BUILDING 03 B. WING	08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

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	liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on observation, records review, and interview, the facility failed enforce 1 of 1 non-smoking policies. This deficient practice could affect staff around the service exit. Findings include: Based on observation with the Executive Director on 08/03/21 during a facility tour between 1:30 p.m. and 4:45 p.m., smoking on property was evident due to at least 6 cigarette butts on the ground around the service hall exit near the kitchen. Based on records review the smoking policy stated smoking is not allowed on the facility's property except in designated area for residents and personal vehicles for staff.	K 0741	1. The allegation is that the facility failed to enforce 1 of 1 non-smoking policies. 2. No residents were effected, but all residents had the potential to be at risk by this deficient practice. 3. In-servicing has been done with staff to educate on smoking policy and where smoking is allowed. All cigarette butts removed from the grounds of the property. 4. To ensure compliance the Maintenance person or designee will be responsible to complete the	08/27/2021

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	Based on interview at the time of observation and records review, the Executive Director confirmed there was smoking on property due to the cigarette butts on the ground outside the kitchen service exit. This finding was acknowledged by the Executive Director at the time of facility tour and again at the exit conference with the Executive Director on 08/03/21 at 5:15 p.m. 3.1-19(b)		QA monitoring tool weekly for 4 weeks, then monthly for 6 months.	
K 0920 SS=E Bldg. 03	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA			

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	12-5 1. Based on observation and interview, the facility failed to ensure power strips in all locations met UL rating of 1363A or 60601-1. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice affects 2 residents. Findings include: Based on observation with the Executive Director on 08/03/21 during a facility tour between 1:30 p.m. and 4:45 p.m., resident room 702 was using 2 power strips within the patient care vicinity for resident's personal electrical equipment items including television that lacked a UL rating of 1363A or 60601-1 label on each power strip. This finding was acknowledged by the Executive Director at the time of facility tour and again at the exit conference with the Executive Director on 08/03/21 at 5:15 p.m. 2. Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 3 residents in front office area.	K 0920	1. The allegation is that the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. 2. No residents were effected, but all residents had the potential to be at risk by this deficient practice. 3. Complete audit has been done. Any power strip that is not approved has been removed from the building. All high power draw equipment was plugged into correct outlet. Care team members educated on the use of proper/approved power strips. 4. To ensure compliance the Maintenance person or designee will be responsible to complete the QA monitoring tool weekly for 4 weeks, then monthly for 6 months.	08/27/2021

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	Findings include: Based on observation with the Executive Director on 08/03/21 during a facility tour between 1:30 p.m. and 4:45 p.m., a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in the Unit Managers office on the 700 Hall. Based on interview at the time of observation, the Executive Director acknowledged a power was supplying power to high power draw equipment. This finding was acknowledged by the Executive Director at the time of facility tour and again at the exit conference with the Executive Director on 08/03/21 at 5:15 p.m. 3.1-19(b)			
K 0712 SS=C Bldg. 04	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 Based on record review and interview, the facility failed to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors in building 2.	K 0712	1. The allegation is that the facility failed to conduct fire drills on unexpected days at unexpected times. 2. No residents were effected, but all residents had the potential	08/27/2021

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	Findings include: Based on records review of the "Fire Drills" and interview with the Executive Director on 08/03/21 between 11:00 a.m. and 1:30 p.m., 7 of 8 fire drills were conducted near the end of the month, on or near the 27th day of the month. The facility has 2 twelve-hour shifts (7-7). These conditions do not allow fire drills to be conducted at unexpected times. This finding was acknowledged by the Executive Director at the time of observation and again at the exit conference with the Executive Director on 08/03/21 at 5:15 p.m. 3.1-19(b)		to be at risk by this deficient practice. 3. Education given that all fire drills will be given at unexpected days and times through out the month. 4. To ensure compliance the Maintenance person or designee will be responsible to complete the QA monitoring tool weekly for 4 weeks, then monthly for 6 months.	
K 0918 SS=F Bldg. 04	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			

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	personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 facility's diesel-powered generator. 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 NFPA110, 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. Findings include: Based on records review and interview with the Executive Director on 08/03/21 between 11:00 a.m. and 1:30 p.m., no documentation of an annual fuel quality test for the diesel generator was available for review. The facility has 2	K 0918	1. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 facility's diesel-powered generator. 2. No resident were effected, but all residents had the potential to be at risk by this deficient practice. 3. The fuel quality test was completed on 2/12/21, the required documentation was not available during survey. 4. To ensure compliance the Executive Director will ensure an annual fuel quality test has been completed and the documentation is available for review.	08/27/2021

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	generators, one Natural gas fired (serving the West building) and one Diesel fired (serving the East building.) Based on interview at the time of records review, the fuel quality testing for the diesel fired generator could not be located. This finding was acknowledged by the Executive Director at the time of records review and again at the exit conference with the Executive Director on 08/03/21 at 5:15 p.m. 3.1-19(b)			