STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155671	A. BUILDING -- B. WING	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OAKWOOD HEALTH CAMPUS	1143 23RD ST TELL CITY, IN 47586

(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: 07/16/24 Facility Number: 002512 Provider Number: 155671 AIM Number: 200278620 At this Emergency Preparedness survey, Oakwood Health Campus was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 98 certified beds and had a census of 74 at the time of this visit. Quality Review completed on 07/18/24 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	The submission of this plan of correction does not indicate an admission by Oakwood Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Oakwood Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mary C. Blocker	Executive Director	08/02/2024

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	procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.			

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	*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August			

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	11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years (36 months). Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: Based on record review on 07/16/24 between 9:45 a.m. and 12:45 p.m. with the Director of Plant	E 0041	The Director of Plant Operations re-ran the generator 4-hour load test and documented results each hour during test to meet regulatory requirements. No further action was needed after load test. All other generator testing, and maintenance were up to date. The Director of Plant Operations was educated by the Executive Director on NFPA 101 Electrical Systems, 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 includes a complete simulated cold start and automatic or manual transfer of all EES loads and are conducted by competent personnel. Maintenance and testing of stored 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	08/01/2024

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	Operations (DPO) and Facility Maintenance Support (FMS) present, the facility was unable to provide documentation of a four hour load test of the emergency generator conducted within the past 36 month period. One monthly generator load test document dated 01/05/24 was presented at the time of record review that indicated it was a 4 hour load test, however, only one hour was actually documented Based on interview at the time of record review, the DPO said the generator did run for four hours under load during the 01/05/24 monthly load test, but was unsure why the documentation only indicated a one hour run time. This finding was reviewed with the Executive Director, DPO, and FMS during the exit conference.		established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. 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). No residents were affected as a result of this deficient practice. QAPI team will monitor monthly for 6 months to ensure no further action is needed.	
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: 07/16/24 Facility Number: 002512 Provider Number: 155671 AIM Number: 200278690 At this Life Safety Code survey, Oakwood Health Campus 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	K 0000	The submission of this plan of correction does not indicate an admission by Oakwood Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Oakwood Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To	

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	Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 98 and had a census of 75 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 07/18/24		this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
K 0222 SS=E Bldg. 01	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			

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	safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 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.			

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	18.2.2.2.4, 19.2.2.2.4 1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 2 locked exit courtyard gates was readily accessible for residents, staff, and visitors. This deficient practice could affect at least 10 residents, as well as staff and visitors. Findings include: Based on observation on 07/16/24 between 12:45 p.m. and 2:45 p.m. during a tour of the facility with the Director of Plant Operations (DPO) and Facility Maintenance Support, the middle exit gate in the front courtyard was equipped with a magnetic lock that required a four digit code on the adjacent keypad to release. When the code was pushed on the keypad the gate did not released from the magnetic locking device. Based on interview at the time of observation, the DPO said she was aware the gate could not be released from the magnetic locking device by using the keypad. She said it has been inspected by a vendor and was told the keypad has gotten wet and will need to be replaced. The magnetic locking device did release the gate when the fire alarm system was tested at the time of observation. When asked at the exit conference how long the gate has not been able to be opened with the keypad, the DPO said about two months. This finding was reviewed with the Executive Director, DPO, and FMS during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 2 exits gates was readily accessible	K 0222	The Director of Plant Operations was educated on 7/19/24 by the Executive Director on NFPA 101-2012 edition sections; 19.2.2.2, 7.2.1.5.10, and 7.2.1.6. The Director of Plant Operations contacted the vendor for repair of gate keypad. Vendor has responded to service call and made all necessary repairs. The Director of Plant Operations will audit the functionality of gate weekly for 1 month and monthly for five months. The results of these inspections will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. No residents were affected by this deficient practice.	08/01/2024

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	for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect at least 10 residents' staff and visitors needing to exit the courtyard. Findings include: Based on observations on 07/16/24 between 12:45 p.m. and 2:45 p.m. during a tour of the facility with the Director of Plant Operations (DPO) and Facility Maintenance Support (FMS), the middle exit gate in the front courtyard was equipped with a magnetic lock that required a four digit code on the adjacent keypad to release. The code to actuate the gate release was not posted. Based on interview at the time of observation, the DPO and FMS acknowledged the code was not posted at the exit gate. This finding was reviewed with the Executive Director, DPO, and FMS during the exit conference. 3.1-19(b)			
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72,			

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	National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time information in accordance with the requirements of NFPA 101- 2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff and visitors. Findings include: Based on an observation and interview during a tour of the facility with the Director of Plant Operations (DPO) and Facility Maintenance Support (FMS) on 07/16/24 at 12:36 p.m. (local time), the time on the red communication sub panel, which is connected to the fire alarm control panel was incorrect. The display on the communication sub panel indicated the time to be 11:11 a.m. Based on interview at the time of observation, the DPO acknowledged the discrepancy in the time displayed on the communication sub panel and said she would speak with the fire alarm system inspection company to get the time set correctly. This finding was reviewed with the Executive Director, DPO, and FMS during the exit conference. 3.1-19(b)	K 0345	The Director of Plant Operations contacted the vendor to come to campus to correct the time on fire alarm control panel. Vendor has responded to the service call and corrected the time on panel. All other functions of the control panel are in working order. The Director of Plant Operations was educated by the Executive Director on NFPA 101, 2012 edition, 19.3.4 and NFPA 72. 2010 edition, 14.1, 14.1.1 The Director of Plant Operations will audit Fire Alarm Control Panel weekly for one month and monthly for five months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. No residents were affected by this deficient practice.	08/01/2024
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems			

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	are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 dry sprinkler system and 1 of 1 wet sprinkler system during 12 of the past 12 months for the sprinkler system's control valves. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff,	K 0353	1. The Director of Operations immediately conducted new inspections to include control valves in the inspection. The Director Plant Operations was educated on proper inspection documentation by Executive Director. The Director of Plant Operations will audit inspection documentation weekly for one month and monthly for five months. The results of these inspections will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. No residents were affected by this deficient practice.	08/01/2024

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	and visitors in the facility. Findings include: Based on record review on 07/16/24 between 9:45 a.m. and 12:45 p.m. with the Director of Plant Operations (DPO) and Facility Maintenance Support (FMS) present, there was no monthly sprinkler system control valves inspection documentation for 12 of the past 12 months available to review for either the dry or wet sprinkler systems. Based on interview at the time of record review, the DPO said he does look at the sprinkler control valves on a weekly basis along with the sprinkler gauges but does not document the control valves as having been inspected. This finding was reviewed with the Executive Director, DPO, and FMS during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 4 sprinkler system gauges on the wet sprinkler system riser were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors. Findings include:		**2.** The Director of Plant Operations contacted and scheduled the Contractor to replace the outdated sprinkler gauges. Contractor responded and changed out the expired gauges. Compliance Date: 8/1/2024 The Director of Plant Operations was educated by the Executive Director on 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. The Director of Plant Operations will audit gauges weekly for one month and monthly for five months. The results of these inspections will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. No residents were affected by this deficient practice.	

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	Based on observations on 07/16/24 between 12:45 p.m. and 2:45 p.m. during a tour of the facility with the Director of Plant Operations (DPO) and Facility Maintenance Support (FMS), the two upper sprinkler gauges on the wet sprinkler system riser had dates of 2017 and 2018 which were past due for replacement or recalibration. No recalibration date information was affixed to the wet sprinkler system gauges. Based on interview at the time of the observation, the DPO confirmed the sprinkler system gauges had not been recalibrated within the most recent five year period and would have the gauges replaced as soon as possible. This finding was reviewed with the Executive Director, DPO, and FMS during the exit conference. 3.1-19(b)			
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide a complete and accurate facility	K 0711	**Immediate Intervention** The Executive Director has	08/01/2024

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	specific written fire safety plan for the protection of all residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the facility's Fire Emergency plan on 07/16/24 between 9:45 a.m. and 12:45 p.m. with the Director of Plant Operations (DPO) and Facility Maintenance Support (FMS) present, the following was noted:		updated the facilities total evacuation plan to include the specific evacuation routes that are posted around facility. The Director of Plant Operations and Executive Director were educated by Plant Operations Support on NFPA 101 Evacuation and Relocation Plan. The plan addresses the basic response required by the staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18/19.7.1.1 through 18/19.7.1.3, 18/19.7.2.1.2, 18/19.7.2.2, 18/19.7.2.3. The Director of Plant Operations will review the facilities Evacuation Plan 1 X per month X 6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. No residents were affected by this deficient practice.	

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	a. There were at least two different versions of a fire safety plan within the Emergency Operations Plan. b. One plan did address evacuation of a compartment, however, that plan did not identify it as a smoke compartment or where the smoke barriers were located in the facility. It indicated at #17 "If the fire is a significant fire evacuate all residents and staff from the effected compartment to another compartment of the building to these pre-assigned areas." There were no pre-assigned areas listed. c. The plan addressed at #14 the use of elevators. The facility is a one story facility with no basement. There is no elevator in the facility. Based on interview at the time of record review, the DPO and FMS acknowledged and agreed that the Fire Emergency plan needs to be updated and accurate to the facility. This finding was reviewed with the Executive Director, DPO, and FMS during the exit conference. 3.1-19(b)			
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 ensure fire drills were held on varied dates for all shifts and quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 07/16/24 between 9:45 a.m. and 12:45 p.m. with the Director of Plant Operations and Facility Maintenance Support present, 10 of 12 fire drills conducted during the past 12 month period were held during the last three days of each month. Based on interview at the time of record review, the DPO acknowledged the dates of all fire drills conducted during the past 12 month period and agreed they were not varied enough by date. This finding was reviewed with the Executive Director, DPO, and FMS during the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	As noted during survey, 10 of the 12 fire drills were held during the last three days of the month. Director of Plant Operations has acknowledged that going forward, all drills will be performed at various times and dates. Compliance Date: 8/1/2024 The Director of Plant Operations was educated by the executive director on the requirements of NFPA 101 concerning fire drills are to be held various times and dates to ensure conditions of drills to be conducted on unexpected days and unpredictable days under varying conditions, at least quarterly on each shift. Executive Director to audit fire drills monthly for 6 months for compliance. The Executive Director and the Director of plant Operations will present information to the QAPI committee. for further recommendations and will continue until the QAPI team determines substantial compliance has been achieved.	08/01/2024
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to			

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	annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored 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 provide complete documentation for the testing of 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years (36 months). Where the assigned class is greater than 4 hours, it shall be	K 0918	The Director of Plant Operations re-ran the generator 4-hour load test and documented results each hour during test to meet regulatory requirements. No further action was needed after load test. All other generator testing, and maintenance were up to date. The Director of Plant Operations was educated by the Executive Director on NFPA 101 Electrical	08/01/2024

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	permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: Based on record review on 07/16/24 between 9:45 a.m. and 12:45 p.m. with the Director of Plant Operations (DPO) and Facility Maintenance Support (FMS) present, the facility was unable to provide documentation of a four hour load test of the emergency generator conducted within the past 36 month period. One monthly generator load test document dated 01/05/24 was presented at the time of record review that indicated it was a 4 hour load test, however, only one hour was actually documented Based on interview at the time of record review, the DPO said the generator did run for four hours under load during the 01/05/24 monthly load test, but was unsure why the documentation only indicated a one hour run time. This finding was reviewed with the Executive Director, DPO, and FMS during the exit conference. 3.1-19(b)		Systems, 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 includes a complete simulated cold start and automatic or manual transfer of all EES loads and are conducted by competent personnel. Maintenance and testing of stored 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 and readily identifiable. 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). No residents were affected as a result of this deficient practice. QAPI team will monitor monthly for 6 months to ensure no further action is needed.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders			

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	Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room where oxygen transferring takes place, was provided with properly working mechanical ventilation. This deficient practice could affect up to 40 residents, staff and visitors in the facility. Findings include: Based on observations on 07/16/24 between 12:45 p.m. and 2:45 p.m. during a tour of the facility with the Director of Plant Operations (DPO) and Facility Maintenance Support (FMS), the oxygen storage/transfer room was equipped with a mechanically vented exhaust fan, however, it was not working at the time of observation. Based on interview prior to entering the oxygen storage/transfer room, the FMS said the exhaust fan was not working and further said a vendor was scheduled to come to the facility tomorrow (07/17/24) to replace the exhaust fan.. This finding was reviewed with the Executive Director, DPO, and FMS during the exit conference. 3.1-19(b)	K 0927	It had already been noted by the Director of Plant Operations during her weekly audits that the exhaust fan in oxygen storage room was not functioning. Director of Plant Operations had already contacted vendor for replacement. Vendor was in campus on 7/17/24 and exhaust fan was replaced. Exhaust fan is now functioning properly. The Director of Plant Operations will continue weekly audits as scheduled and report any issues to Executive Director immediately. No residents were affected by this deficient practice.	08/01/2024

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