

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155850		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 08/13/2024	
NAME OF PROVIDER OR SUPPLIER  BELLTOWER HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 5805 NORTH FIR ROAD GRANGER, IN 46530			
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E 0000  Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 08/13/24</p> <p>Facility Number: 013644 Provider Number: 155850 AIM Number: 201381180</p> <p>At this Emergency Preparedness survey, Belltower Health &amp; Rehabilitation Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73</p> <p>The facility has 96 certified beds. At the time of the survey, the census was 83.</p> <p>Quality Review completed on 08/15/24</p>			E 0000			
E 0039 SS=F Bldg. --	<p>403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.542(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2)</p> <p>EP Testing Requirements</p> <p>§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).</p> <p>*[For ASCs at §416.54, CORFs at §485.68,</p>						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Marti Carmean

Administrator

08/29/2024

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

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	<p>REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <p>(i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop</p>						

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	<p>exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For Hospices at 418.113(d):]</p> <p>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct</p>						

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	<p>exercises to test the emergency plan twice per year. The hospice must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]</p> <p>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p>						

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	<p>(i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not</p>						

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	<p>accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.</p> <p>*[For LTC Facilities at §483.73(d):]</p> <p>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual,</p>						

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	<p>facility-based functional exercise.</p> <p>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.</p> <p>*[For ICF/IIDs at §483.475(d):</p> <p>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.</p> <p>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires</p>						

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	<p>activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</p> <p>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual,</p>						



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	<p>facility based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.</p> <p>*[For OPOs at §486.360]</p> <p>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.</p>						

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	<p>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>*[ RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may</p>			E 0039	<p>1 The Community Based second training has been scheduled on 9.5.23. There were no residents directly affected by the alleged deficient practice. 2 Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3 The Maintenance Director has been educated by the Administrator on the requirement as it relates to twice a year community-based training. This education will be completed by September 9, 2024 4 Community-Based Training will be reviewed by QAPI quarterly and annually thereafter or until</p>		09/09/2024

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E 0041 SS=F Bldg. --	<p>include, but is not limited to the following:</p> <p>a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.</p> <p>b. A mock disaster drill; or</p> <p>c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Administrator on 08/13/24 between 10:36 a.m. and 1:04 p.m., documentation of a community-based exercise conducted in July of 2024 was produced, however the facility was unable to provide documentation for a second exercise of choice during the survey. Based on interview at the time of record review, the Administrator stated that the facility conducted a table-top exercise later last year for a exercise, however she was unaware where the documentation could be located and acknowledged that the documentation could not be produced at the time of the survey.</p> <p>The finding was discussed with the Administrator at exit conference.</p> <p>482.15(e), 483.73(e), 485.542(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation:</p>				<p>compliance is achieved.</p> <p>5    Date of Compliance September 9, 2024</p>		

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NAME OF PROVIDER OR SUPPLIER  BELLTOWER HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5805 NORTH FIR ROAD GRANGER, IN 46530			
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	<p>(e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.</p> <p>§483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.</p> <p>§482.15(e)(1), §483.73(e)(1), §485.542(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.</p> <p>482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(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.</p> <p>482.15(e)(3), §483.73(e)(3), §485.625(e)</p>						

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	<p>(3),§485.542(e)(2) 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.</p> <p>*[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and 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: <a href="http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html">http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html</a>. 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.</p>						

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	<p>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.</p> <p>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.</p> <p>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.</p> <p>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.</p> <p>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.</p> <p>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.</p> <p>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.</p> <p>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.</p> <p>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..</p> <p>Based on record review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Administrator on 08/13/24 between 10:36 a.m. and 1:04 p.m., the generator lacked the 3-year, 4-hour load exercise required by LSC and NFPA 110. Based on interview at the time of record review, the Administrator stated that the Maintenance Director was on vacation and was unable to locate the needed documentation. She further acknowledged that the documentation could not be located at the time of the survey.</p>			E 0041	<p>1 The 3-year 4-hour load test has been scheduled on 8.30.24. There were no residents directly affected by the alleged deficient practice.</p> <p>2 Residents residing at the facility have the potential to be affected by the alleged deficient practice.</p> <p>3 The Maintenance Director has been educated by the Administrator on the requirement as it relates to the 4-hour load requirement. This education will be completed by September 9, 2024.</p> <p>4 Completed Load tests will be reviewed at QAPI for the first month and annually thereafter.</p> <p>5 Date of Compliance September 9, 2024</p>		09/09/2024

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K 0000  Bldg. 01	<p>The finding was reviewed with the Administrator at the exit conference.</p> <p>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).</p> <p>Survey Date: 08/13/24</p> <p>Facility Number: 013644 Provider Number: 155850 AIM Number: 201381180</p> <p>At this Life Safety Code survey, Belltower Health and Rehabilitation 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.</p> <p>This one-story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a monitored fire alarm system with hard wired smoke detection in resident rooms, in corridors and in spaces open to the corridors. The facility has a capacity of 96 and had a census of 83 at the time of this survey</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review completed on 08/15/24</p>			K 0000			

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K 0324 SS=E Bldg. 01	<p>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 ensure 1 of 1 kitchen hood extinguishing system provided complete coverage for equipment that produces grease-laden vapors. NFPA 96, 2011 edition, Section 10.1.2 requires cooking equipment that produces grease-laden vapors and that might be a source of ignition of grease in the hood, grease removal device, or duct shall be protected by fire-extinguishing equipment. Section 12.1.2.2 states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire</p>			K 0324	<p>1 The two suppression nozzles have been realigned to ensure complete coverage to the stove top. There were no residents directly affected by the alleged deficient practice. 2 Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3 The Maintenance Director and Dietary staff have been educated by the Administrator on the requirement as it relates to cooking facilities and the</p>		09/09/2024



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K 0353 SS=F Bldg. 01	<p>extinguishing system. This deficient practice could affect approximately 20 residents and staff within the kitchen and the adjacent dining area.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Administrator on 08/13/24 between 1:38 p.m. and 3:01 p.m., a gas cooktop appliance in use was not completely under the hood and was not covered by the suppression system. The position of the two suppression nozzles, if activated, would hit the top shelf/backsplash of the cooking appliance. Based on interview at the time of observation, the Administrator acknowledged that the cooking appliance top was not completely covered by the suppression system.</p> <p>The finding was reviewed with the Administrator at exit conference.</p> <p>3.1-19(b)</p> <p>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.</p> <p>a) Date sprinkler system last checked</p> <p>b) Who provided system test</p> <p>c) Water system supply source</p>				<p>suppression coverage needed for the cook top stove.</p> <p>Weekly Sanitation audits will be conducted by the Administrator and/or designee. Any findings related to the suppression nozzles will be addressed as identified.</p> <p>4 Weekly Sanitation audits will be forwarded to QAPI for review, these audits will be reviewed monthly for a period of 12-months or until compliance is achieved.</p> <p>5 Date of Compliance September 9, 2024</p>		

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	<p>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</p> <p>Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review with the Administrator on 08/13/24 between 10:36 a.m. and 1:04 p.m., the facility could not produce documentation for a third quarter (July, August or September) of 2023</p>			K 0353	<p>1 The third quarter sprinkler inspection date has since surpassed, so therefore corrections could not be made. The current quarter inspection was completed on August 23, 2024. There were no residents directly affected by the alleged deficient practice.</p> <p>2 Residents residing at the facility have the potential to be affected by the alleged deficient practice.</p> <p>3 The Maintenance Director has been educated by the Administrator on the requirement as it relates to Quarterly Sprinkler inspections. This education will be completed by September 9, 2024</p> <p>4 Sprinkler Inspection reports will be forwarded to QAPI for review on a quarterly basis for a period of 12-months.</p> <p>5 Date of Compliance September 9, 2024</p>		09/09/2024

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K 0761 SS=E Bldg. 01	<p>could not be produced at the time of the survey. Based on interview at the time of record review, the Administrator acknowledged that the documentation was missing and further stated that she was unaware if the sprinkler company was out during that period in 2023. During further investigation, the Administrator was able to produce an email stating that the sprinkler company was scheduled to come out later in the month for the third quarter inspection in 2024.</p> <p>The finding was discussed with the Administrator at exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Maintenance, Inspection &amp; Testing - Doors Maintenance, Inspection &amp; Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) Based on record review and interview, the facility failed to ensure annual inspection and testing of 2 of 2 oxygen storage/transfilling fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be</p>			K 0761	1 The two Oxygen Doors have been inspected by the Maintenance Director with findings of missing or broken parts, adequate clearances and self closes without difficulty. There		09/09/2024

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	<p>permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified:</p> <p>(1) No open holes or breaks exist in surfaces of either the door or frame.</p> <p>(2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.</p> <p>(3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.</p> <p>(4) No parts are missing or broken.</p> <p>(5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.</p> <p>(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.</p> <p>(7) If a coordinator is installed, the inactive leaf closes before the active leaf.</p> <p>(8) Latching hardware operates and secures the door when it is in the closed position.</p> <p>(9) Auxiliary hardware items that interfere or</p>				<p>were no residents directly affected by the alleged deficient practice.</p> <p>2 Residents residing at the facility have the potential to be affected by the alleged deficient practice.</p> <p>3 The Maintenance Director has been educated on the requirement as it relates to annual inspections to fire doors that include hazardous areas. This education will be completed by September 9, 2024.</p> <p>4 Door Inspections will be forwarded to QAPI for review, these inspections will be reviewed monthly for a period of 12-months or until compliance is achieved.</p> <p>5 Date of Compliance September 9, 2024</p>		

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K 0781 SS=E Bldg. 01	<p>prohibit operation are not installed on the door or frame.</p> <p>(10) No field modifications to the door assembly have been performed that void the label.</p> <p>(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect 20 residents in one smoke compartment.</p> <p>Findings include:</p> <p>Based on record review with the Administrator on 08/13/24 between 10:36 a.m. and 1:04 p.m. fire door inspections had been conducted on 04/05/24. However, the fire door inspections did not include the two oxygen storage/transfilling rooms in the facility. Based on interview at the time of record review, the Administrator acknowledged the lack of documentation and further stated she was unaware where else the documentation could be as the Maintenance Director was unavailable at the time of the survey.</p> <p>The finding was discussed with the Administrator at exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation and interview, the facility failed to ensure 3 of 3 portable space heaters were</p>			K 0781	1 The Space heaters were removed from the front desk,		09/09/2024

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K 0918 SS=F Bldg. 01	<p>not used in the facility. This deficient practice could affect approximately 10 staff and an unknown number of residents.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Administrator on 08/13/24 between 1:38 p.m. and 3:01 p.m., two portable space heaters were ready to be used in the Director of Nursing office and the Payroll office. During record review earlier in the survey, the Administrator advised the surveyor that the facilities policy is that space heaters are not allowed anywhere and will be removed if they are being used. Also, when entering the facility to start the survey, the front desk attendant had a space heater on the desk which was in use. When the surveyor began the introduction she had put away the space heater. Based on interview at the time of observations, the Administrator agreed that there were space heaters within the offices and further stated that staff should be aware that space heaters are not allowed anywhere in the facility.</p> <p>Findings were discussed with the Administrator at exit conference.</p> <p>3.1-19(b)</p>			<p>payroll office and the Director of Nursing's office upon discovery. There were not in use in the payroll or DON's office when discovered. There were no residents directly affected by the alleged deficient practice.</p> <p>2 Residents residing at the facility have the potential to be affected by the alleged deficient practice.</p> <p>3 The Front Desk Personnel, Payroll and Director of Nursing have been educated by the Administrator on the requirement as it relates to Space Heater use. This education will be completed by September 9, 2024</p> <p>Environmental rounds will be conducted by the Maintenance Director weekly that includes space heater use.</p> <p>4 Environmental rounds will be forwarded to QAPI for review, this review will take place monthly for a period of 12-months or until compliance is achieved.</p> <p>5 Date of Compliance September 9, 2024</p>			
	<p>NFPA 101</p> <p>Electrical Systems - Essential Electric Syste</p> <p>Electrical Systems - Essential Electric System Maintenance and Testing</p> <p>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</p>						

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155850		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 08/13/2024	
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	<p>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.</p> <p>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.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>Based on record review and interview, the facility failed to maintain 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. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours.</p>			K 0918	<p>1 The 3-year 4-hour load test has been scheduled on 8.30.24. There were no residents directly affected by the alleged deficient practice.</p> <p>2 Residents residing at the facility have the potential to be affected by the alleged deficient practice.</p> <p>3 The Maintenance Director has been educated by the</p>		09/09/2024

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K 0927 SS=E Bldg. 01	<p>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.</p> <p>Findings include:</p> <p>During record review with the Administrator on 08/13/24 between 10:36 a.m. and 1:04 p.m., documentation of a four hour run test for the emergency generator conducted within the last 36 months was not provided for review. The last documented four hour exercise was conducted in June of 2021. Based on interview at the time of record review, the Administrator acknowledged that the documentation was over 36 months old and was unsure if one had been documented later than that. She further explained that the generator has ran under load for that amount of time, but documentation was missing and could not be produced during the survey.</p> <p>This finding was reviewed with the Administrator at the exit conference.</p> <p>3.1-19(b)</p>				<p>Administrator on the requirement as it relates to the 4-hour load requirement. This education will be completed by September 9, 2024.</p> <p>4 Completed Load tests will be reviewed at QAPI for the first month and annually thereafter.</p> <p>5 Date of Compliance September 9, 2024</p>		
	<p>NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders 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</p>						



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	<p>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)</p> <p>1. Based on record review and interview, the facility failed to ensure staff was properly trained on trans-filling procedures in 2 of 2 oxygen storage room where oxygen transferring takes place. NFPA 99 2012 edition, 11.5.2.3.1 (4) the individual trans-filling the container(s) has been properly trained in the trans-filling procedures. This deficient practice could affect approximately 40 residents and staff.</p> <p>Findings include:</p> <p>Based on record review with the Administrator on 08/13/24 between 10:36 a.m. and 1:04 p.m., no documentation was available for review to indicate staff that trans-fill liquid oxygen were properly trained. Based on interview at the time of observation, the Administrator stated the staff are trained on transfilling liquid oxygen, however was unsure when the last time training had occurred nor could find documentation to prove training had been completed.</p> <p>The finding was discussed with the Administrator at exit conference.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 2 oxygen storage rooms where oxygen transferring takes place, was provided with properly working mechanical ventilation. NFPA 99 2012 edition, 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical exhaust to maintain a</p>	K 0927	<p>1 The nursing staff have had competencies completed as it relates to transfilling oxygen. The venting has been repaired so there is adequate ventilation and drawing air outward as required. There were no residents directly affected by the alleged deficient practice.</p> <p>2 Residents residing at the facility have the potential to be affected by the alleged deficient practice.</p> <p>3 Facility will be educated by September 9, 2024 by the Administrator on Oxygen transfilling with competencies completed on an annual basis. The Maintenance Director has been educated by the administrator on the requirement as it relates for proper ventilation for Oxygen Room. This education will be completed by September 9, 2024.</p> <p>Oxygen room ventilation will be checked on a monthly basis for adequate air exchange.</p> <p>4 Monthly environmental rounds will be forwarded to QAPI for review, results of those rounds in addition to annual competencies for direct care staff will be presented monthly for a period of 12-months or until compliance is achieved.</p>		09/09/2024		

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	<p>negative pressure in the space continuously. This deficient practice could affect approximately 10 staff and an unknown number of residents.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility the Administrator on 08/13/24 between 1:38 p.m. and 3:01 p.m., the oxygen storage/transfer room, in the service hall, contained large liquid oxygen tanks. There was one mechanical vent to the outside, however when testing the vent was not operating and drawing air with a sheet of paper. Based on interview at the time of observation, the Administrator acknowledged that the vent fan was not properly working when tested and acknowledged the need for mechanical ventilation in the transfilling room.</p> <p>The finding was discussed with the Administrator at exit conference.</p> <p>3.1-19(b)</p>				<p>5 Date of Compliance September 9, 2024</p>		