STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155278	A. BUILDING -- B. WING	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER	155 E BURKS DR BLOOMINGTON, IN 47401

(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: 000177 Provider Number: 155278 AIM Number: 100289860 At this Emergency Preparedness survey, Brickyard HealthCare - Bloomington Care Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 153 certified beds. At the time of the survey, the census was 109. Quality Review completed on 07/18/24	E 0000	The submission of this Plan of Correction, for survey event ID FGG21 from 7/16 2024, does not indicate an admission by Bloomington Care Center that the findings and allegations contained herein are an accurate and true depiction of the quality of care and services provided to the residents of Bloomington Care Center. 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 Comprehensive Health Care Facilities. To this end, this Plan of Correction shall serve as a 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 We are asking for Paper Compliance for this survey.	
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
Scott Swaby	Exe	08/01/2024

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

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	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). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director and Executive Director on 07/16/24 from 10:35 a.m. to 2:15 p.m., no documentation was available for review to show the diesel generator set in service was inspected for 15 weeks between 10/09/23 and 04/08/24. Based on an interview at the time of record review, the Executive Director confirmed the missing weekly inspections and stated he searched the record keeping system and was unable to locate the missing visual inspections. This finding was discussed with the Executive Director and Maintenance Director at the exit conference.	E 0041	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** No residents were affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All Residents have the potential to be affected by the alleged deficient practice. No other residents were affected. Maintenance staff were educated on completing weekly checks and documentation will be completed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**	08/12/2024

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K 0000			The Maintenance staff were educated on the policy of "Emergency Generator Testing" (Exhibit A) and the importance of printing each test and placing in the book. The audit tool "Life Safety Survey 2024" (Exhibit B) will be utilized to determine Compliance. The Maintenance Director or his designee will complete the audit weekly for 2 months, bi-weekly for 2 months, and monthly for 2 months. The audit will be submitted to the Quality Assurance Committee monthly for review until substantial compliance is achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date;** **8/12/2024**	

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Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/16/24 Facility Number: 000177 Provider Number: 155278 AIM Number: 100289860 At this Life Safety Code survey, Brickyard HealthCare -Bloomington Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility with a partial basement was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 153 and had a census of 109 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 07/18/24	K 0000	The submission of this Plan of Correction, for survey event ID FGG21 from 7/16 2024, does not indicate an admission by Bloomington Care Center that the findings and allegations contained herein are an accurate and true depiction of the quality of care and services provided to the residents of Bloomington Care Center. 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 Comprehensive Health Care Facilities. To this end, this Plan of Correction shall serve as a 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 We are asking for Paper Compliance for this survey.	
K 0300 SS=F	NFPA 101 Protection - Other			

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Bldg. 01	Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, interview and observation, the facility failed to ensure documentation for the preventative maintenance of all battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of the 'Test Battery Operated Smoke Detectors' reports on 07/16/24 from 10:35 a.m. to 2:15 p.m. with the Maintenance Director and Executive Director present, the itemized list of resident room battery operated smoke alarms are tested for functionality on a monthly basis during the past twelve months. The March 2024 monthly inspection stated 'New Detectors installed 03/06/2024. Based on observations between 2:15 p.m. and 3:50 p.m. during a tour of the facility with the Maintenance Director, battery operated smoke alarms were observed in all resident sleeping	K 0300	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** No Residents were affected by this alleged deficient practice. The alarm functioned as it should. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** No other residents were affected by this alleged deficient practice. The Manufacturers Guidelines will be followed for checking this device. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Education was provided to the Maintenance Department on the Manufacturers Guideline for the Kidde model i9050 (Exhibit C).	08/12/2024

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	rooms. The Kidde model i9050 battery operated smoke detector in resident room 142 was removed from the ceiling and the manufacturer recommendation called for weekly testing. The date '03/06/24' was wrote on the outside of the detector in black marker. Based on interview at the time of observation, the Maintenance Director confirmed the smoke detector called for weekly testing and stated the task is set up to test on a monthly basis which he has been doing since being hired on April 2024. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		Weekly checks were added to the TELS system All Kidde smoke alarms model i9050 will be monitored weekly. The audit tool “Life Safety Survey 2024” (Exhibit B) will be utilized to determine compliance. The Maintenance Director or his designee will complete the audit weekly for two months, bi-weekly for 2 months, and monthly for 2 months. The audits will be submitted to the Quality Assurance Committee monthly until substantial compliance is Achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date;** **8/12/2024**	
K 0321 SS=D Bldg. 01	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			

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	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) 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 1 of 17 hazardous areas such as laundry rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect staff in the vicinity of the Laundry room in the basement. Findings include: Based on observation with the Maintenance	K 0321	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** No Residents were affected by the alleged deficient practice. The door was adjusted and now closes properly.	08/12/2024

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	155278	A. BUILDING 01 B. WING	07/16/2024

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	Director during a tour of the facility at 3:45 p.m. on 07/16/24, the corridor door to the Laundry room by the fuel fired dryers failed to latch into the frame when it self closed. The corridor door was tested five times from the fully open position and it failed to latch each time. Based on interview at the time of the observation, the Maintenance Director agreed the aforementioned hazardous area was not separated from other spaces by smoke resistant partitions and doors and stated he would work on the door and make sure it latches. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by the alleged deficient practice. No other residents were affected. The door was adjusted and now closes properly. All hazardous areas were assessed and all doors were working properly. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Staff were education on “Protection Hazardous areas – Enclosure” (Exhibit D). The audit tool “Life Safety Survey 2024” (Exhibit B) will be utilized to determine compliance. The Maintenance Director or his designee will complete the audit weekly for 2 months, bi-monthly for 2 months, and monthly for 2 months. The audit will be submitted to the Quality Assurance Committee monthly until substantial Compliance is achieved. **By what date the systemic changes for each deficiency will be completed. After**	

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			submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date; **8/12/2024**	
K 0355 SS=B Bldg. 01	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 1 portable fire extinguisher in the corridor outside resident room #6 and #8 was kept in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 1-6.3 states Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of a fire. Preferable they shall be located along normal paths of travel, including exits from areas. This deficient practice could affect as many as 28 residents, 6 staff and 2 visitors on station one. Findings include: Based on observation during a tour of the facility	K 0355	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** No resident was affected by the alleged deficient practice. The lift was immediately moved during the survey tour. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	08/12/2024

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	with Maintenance Director on 07/16/24 at 3:00 p.m., the ABC portable fire extinguisher located in the corridor immediately outside resident rooms #6 and #8 was obstructed by a patient lift Hoyer device. Based on interview at the time of observation, the Maintenance Director confirmed the fire extinguisher was obstructed and not readily accessible, and moved the Hoyer lift from in front of the fire extinguisher upon observation. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		**action(s) will be taken;** All residents have the potential to be affected by the alleged deficient practice. No other residents were affected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** All Staff were educated on the Policy of "Fire Extinguishers" (Exhibit E). The audit tool "Life Safety Survey 2024" (Exhibit B) will be utilized to determine compliance. The Maintenance Director or designee will complete the audit weekly for 2 months, bi-monthly for 2 months, and monthly for 2 months. The Audit will be submitted monthly to the Quality Assurance Committee until substantial compliance is achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction**	

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	155278	A. BUILDING 01 B. WING	07/16/2024

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			with the updated plan of correction date; **8/12/2024**	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 1 of 2 resident seating areas open to the corridor in Horizons were separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect at least 15 residents, as well as staff in the Horizons wing. Findings include: Based on observations on 07/16/24 at 2:54 p.m. during a tour of the facility with the Maintenance Director, the seating area next to resident room 29 was open to the corridor without direct	K 0361	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** No residents were affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by the deficient practice. No other residents were affected. A wired smoke detector will be installed to meet compliance. All other similar areas were assessed with no problems noted. **What measures will be put into**	08/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER	155 E BURKS DR BLOOMINGTON, IN 47401

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	supervision from a 24 hour station (Nurses' Station). Furthermore, LSC 19.3.6.1(7) was not met because the seating area was not protected by an electrically supervised automatic smoke detection system. Based on interview at the time of observation, the Maintenance Director agreed the seating area was not provided with an electrically supervised automatic smoke detector or a door to the egress corridor and was not directly supervised by a 24 hour station (Nurses' Station). This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		**place and what systemic changes will be made to ensure that the deficient practice does not recur:** The maintenance staff were educated on K-361 “Protection Corridors-Areas open to corridor” (Exhibit F). A new wired smoke detector is scheduled to be installed by Safecare. An audit tool “Life Safety Survey 2024” (Exhibit B) will be utilized to determine compliance. The Maintenance Director or his designee will complete the audit weekly for 2 months, bi-weekly for 2 months, and monthly for 2 months. The audit will be submitted to the Quality Assurance Committee until Substantial Compliance is achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date;** **8/12/2024**	

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K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure all ground fault circuit interrupter (GFCI) were properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could affect staff in clean utility room on station one. Findings include: Based on observation with the Maintenance Director on 07/16/24 at 2:42 p.m., when the two receptacles located on either side of the sink in the clean utility room across from the station one nurse station were tested with a GFCI tester, the electric receptacles did not trip. Based on interview at the time of observation, the Maintenance Director confirmed the non GFCI electric receptacles within two feet of the sink in the station one clean utility room did not trip when tested. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 2. Based on observation, the facility failed to	K 0511	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** There were no residents affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents and employees could be affected by this deficient practice. No residents or employees were affected. The two receptacles were removed and a cover plate was put over both outlets. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**	08/12/2024

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	ensure all electrical junction boxes observed were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect staff in the kitchen. Findings include: Based on observation with the Maintenance Director during a tour of the facility at 3:20 p.m. on 07/16/24, an electrical junction box without a cover and with exposed electrical wiring was noted in the space above the drop ceiling in the kitchen sprinkler riser room. Based on interview at the time of the observation, the Maintenance Director confimred the electrical junction box was not provided with a cover. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		The Maintenance Department reviewed the policy of "Electrical Safety" (Exhibit G). The audit tool "Life Safety Survey 2024" (Exhibit B) will be utilized to determine compliance. The Maintenance Director or designee will complete the audit weekly for 2 months, bi-weekly for 2 months, and monthly for 2 months to determine compliance. The audit will be submitted to the Quality Assurance Team monthly until Substantial Compliance has been achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date;** **8/12/2024**	
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			

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	10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored 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 a written record of weekly inspections for the generator was maintained for 15 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be	K 0918	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** No residents were affected by the alleged deficient practice.	08/12/2024

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	inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director and Executive Director on 07/16/24 from 10:35 a.m. to 2:15 p.m., no documentation was available for review to show the diesel generator sets in service were inspected for 15 weeks between 10/09/23 and 04/08/24. Based on an interview at the time of record review, the Executive Director confirmed the missing weekly inspections and stated he searched the record keeping system and was unable to locate the missing weekly visual inspections. This finding was discussed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All Residents have the potential to be affected by the alleged deficient practice. No other residents were affected. Maintenance staff were educated on completing weekly checks and documentation will be completed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance staff were educated on the policy of "Emergency Generator Testing" (Exhibit A) and the importance of printing each test and placing in the book. The audit tool "Life Safety Survey 2024" (Exhibit B) will be utilized to determine Compliance. The Maintenance Director or his designee will complete the audit weekly for 2 months, bi-weekly for 2 months, and monthly for 2 months. The audit will be submitted to the Quality Assurance Committee monthly for review until substantial compliance is achieved. **By what date the systemic**	

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			changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date; **8/12/2024**	