STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	824350	A. BUILDING _____ B. WING _____	**9/20/2022**

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FOUR SEASONS NURSING CENTER OF WESTLAND	**8365 NEWBURGH RD WESTLAND, MI 48185**

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E0000 SS=	Initial Comments On September 20, 2022, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Four Seasons Nursing Center Of Westland was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		
E0015 SS= F	Subsistence Needs for Staff and Patients §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal.	E0015	1.) The required emergency food supply has been segregated and labeled from non-emergency stored food in the dry storage room. The required emergency water supply has been properly segregated and labeled in the maintenance storage area. 2.) The Dietary Manager and Director of maintenance have been re-educated as well as dietary staff for correct utilization and storage of said items. 3.) The Dietary Manager will audit to ensure the Emergency food and water supply are maintained, labeled, and rotated accordingly. Findings during monitoring will be submitted to QAPI committee for review. 4.) The Dietary manager is responsible for continued monitoring. The Administrator is responsible for continued compliance. 5.) Date of completion and compliance: October 17th, 2022.	10/17/2022

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

Electronically Signed | 10/17/2022

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 90 days 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 14 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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	*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to develop, at a minimum, policies and procedures that address; the provision of subsistence needs for staff and patients whether they evacuate or shelter in place, including, but not limited to: Food, water, medical and pharmaceutical supplies, alternate sources of energy to maintain temperatures to protect patient health and safety and for the safe and sanitary storage of provisions, emergency lighting, fire detection, extinguishing and alarm systems, and sewage and waste disposal. This deficient practice could affect all facility occupants in the event of a fire, man-made, natural, geographical or facility-based emergency. Findings Include: 1) On September 20, 2022 at 2:00 PM, observation revealed the facility failed to properly segregate and identify their required emergency			

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	food supply from their regular non-emergency stored food supply in the Dry Storage Room. 2) On September 20, 2022 at 2:40 PM, observation revealed the facility failed to properly segregate the require emergency water supply from other stored water located in the Maintenance Storage area. These deficient practices could lead to confusion by the Dietary Staff and other staff member in incorrect utilizations of required emergency provisions and ultimately depletions of critical emergency resources. These findings were confirmed in interview with the facility Maintenance Supervisor at the time of observation.			
K0223 SS= E	Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure doors in an exit passageway,	K0223	1.) The propped open fire-rated doors to the kitchen dish room from the main dining room, the main dining room to the main kitchen, the main boiler/electrical room, and the soiled linen to the main laundry room have been closed and props removed. The fire-rated door to the archive room self-closing arm has been connected. 2.) All staff have been educated to ensure that doors are kept in the closed position and not propped open. 3.) The Maintenance Director or designee will monitor doors daily to ensure doors are kept in the closed position and that all self-closing arms are properly connected and functioning. Findings during monitoring will be submitted to QAPI committee for review. 4.) The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued compliance. 5.) Date of completion and compliance: October 17th, 2022.	10/17/2022

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	stairway enclosure, horizontal exit, smoke barrier or hazardous area are self-closing and kept in the closed position unless held open in accordance with 7.2.1.8.2, as required by 19.2.2.2.7 and 19.2.2.2.8. This deficient practice could affect more than a limited number of facility occupants in the event of a fire. Findings Include: On September 20, 2022 the following deficiencies were observed at the times and locations indicated: 1) At 10:10 AM, fire-rated door to the Kitchen Dish Room from the main Dining Room propped open with a door chock from 10:10 AM to 11:20 AM. 2) At 1:37 PM, fire-rated door from the main Dining Room to the main Kitchen propped open with a floor hazard sign. 3) At 1:52, fire-rated door to the Archive Room self-closure device closing arm disconnected. 4) At 2:55 PM, fire-rated door to the main Boiler/Electrical Room propped open. 5) At 3:07 PM, fire-rated door to Soiled Linen to the main Laundry propped open with a door chock. These findings were confirmed in interview with the facility Maintenance Supervisor at the time of observation.			
K0324 SS= E	Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking	K0324	1.) The Kitchen range hood has been properly aligned in relation to the nozzles on the suppression system. 2.) The Dietary staff have been educated on	10/17/2022

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	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 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure cooking facilities are protected in accordance with NFPA 96, unless meeting the requirements of 19.3.2.5.2, 19.3.2.5.3 or 19.3.2.4.4, as required by 19.3.2.5.1 through 19.3.2.5.5, 9.2.3 and TIA 12-2. This deficient practice could affect more than a limited number of facility occupants in the event of a fire involving appliances and/or components covered by the installed hood suppression system. Findings Include: On September 20, 2022 at 2:12 PM, observation revealed the nozzles on the installed range hood suppression system were misaligned in relation to the range hood surface. These findings were confirmed in interview with the facility Maintenance Supervisor at the time of		properly aligning the range with the nozzles on the suppression system. 3.) The Dietary Manager or designee will monitor alignment daily. Findings during monitoring will be submitted to QAPI committee for review. 4.) The Dietary Manager is responsible for continued monitoring. The Administrator is responsible for continued compliance. 5.) Date of completion and compliance: October 17th, 2022	

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	observation.			
K0353 SS= E	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. 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 This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure the automatic sprinkler and standpipe systems are inspected, tested and maintained in accordance with NFPA 25, and records are readily available as required by 9.7.5, 9.7.7, 9.7.8 and NFPA 25. This deficient practice could affect more than a limited number of facility occupants in the event of a fire. Findings Include: On September 20, 2022 at 11:45 AM, record review revealed the facility failed to provide evidence of the required Quarterly Flow Test for their installed automatic fire sprinkler system for the 1st to 3rd Quarter 2021, and 3rd Quarter 2022.	K0353	1.) The required quarterly flow test for the automatic fire sprinkler system was completed and documentation has been received. All sprinkler heads have been cleaned, the required sprinkler inventory lists have been placed in the cabinets in the boiler room, all stock items stored within 18 have been removed, and the ceiling tile penetration in the west dining room repaired. 2.) The environmental staff have been re-educated on proper cleaning / dusting of sprinkler heads and all staff education provided on storing of items within 18 of sprinkler heads. 3.) The Director of Maintenance is responsible for on-going monitoring. Findings during monitoring will be submitted to QAPI committee for review. 4.) The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued compliance. 5.) Date of completion and compliance: October 17th, 2022	10/17/2022

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	On September 20, 2022 the following deficient were observed at the times and locations indicated: 1) At 2:08 PM, dirty sprinklers at the Tray Line in the Kitchen, 2) At 2:09 PM, stock items stored within 18" of sprinkler head in walk-in freezer in the Kitchen. 3) At 2:10 PM, stock items stored within 18" of sprinkler head in walk-in refrigerator in Kitchen. 4) At 2:30 PM, dirty sprinkler heads in main lobby at Admission Office. 5) At 2:45 PM, stock items stored within 18" of sprinkler heads in Maintenance Office/Shop. 6) At 2:50 PM, dirty sprinkler head in Boiler Room. 7) At 2:52 PM, both sprinkler cabinets in Boiler Room missing the required sprinkler inventory lists. 8) at 3:05 PM, dirty sprinkler heads throughout main Laundry. 9) At 3:09 PM, stock items stored within 18" of sprinkler head in main Laundry by dryers. 10) At 4:43 PM, ceiling tile penetration at sprinkler branch line in the West Dining Room. These findings were confirmed in interview with the facility Maintenance Supervisor at the time of record review and observation.			

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K0355 SS= D	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 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure portable fire extinguishers are selected, installed, inspected and maintained in accordance with NFPA 10, as required by 19.3.5.12. This deficient practice could affect an isolated number of facility occupants in the event of a fire. Findings Include: 1) On September 20, 2022 at 2:11 PM, observation revealed the ABC fire extinguisher cabinet in the Kitchen was obstructed by a metal rack stacked with large rubber floor mates. 2) On September 20, 2022 at 2:56 PM, observation revealed the fire extinguisher in the main Boiler Room was obstructed by the door being propped open with plastic coated wire attached around the door handle. These findings were confirmed in interview with the facility Maintenance Supervisor at the time of observation.	K0355	1.) The metal rack stacked with large rubber floor mates has been removed from obstructing the fire extinguisher in the kitchen and the obstructed extinguisher in the main boiler room d/t the door propped open has been closed. 2.) The dietary and environmental staff have been re-educated on keeping fire extinguishers clear from obstructed access. 3.) The Director of Maintenance is responsible for on-going monitoring. Findings during monitoring will be submitted to QAPI committee for review. 4.) The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued compliance. 5.) Date of completion and compliance: October 17th, 2022	10/17/2022
K0372 SS= E	Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an	K0372	1.) The fire-rated door from Maintenance Corridor to employee□s dock, personal laundry room in summer hall, soiled linen in summer hall, storage in autumn hall, dining room in spring hall, and main dining room to kitchen have been corrected to positively latch	10/17/2022

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	atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoke barriers were constructed to a minimum 1/2-hour fire resistance rating in accordance with 8.5, as required by 19.3.7.3 and 8.6.7.1(1). This deficient practice could affect more than a limited number occupants in the event of a fire.. Findings Include: On September 20, 2022 the following deficiencies were observed at the times an locations indicated: 1) At 2:45 PM, fire-rated door from Maintenance Corridor to Employees Dock failed to positively latch when tested. 1) At 3:02 PM, fire-rated door to Personal Laundry Room in Summer Hall corridor failed to positively latch when tested. 2) At 3:03 PM, fire-rated door to Soiled Lined in Summer Hall corridor failed to positively latch when tested. 3) At 3:31 PM, fire-rated door to Deceased Storage in Autumn Hall corridor failed to positively latch when tested. 4) At 4:41 PM, fire-rated door to dining room in		when tested. 2.) The maintenance staff have been re-educated on daily monitoring / testing to ensure all smoke barrier doors positively latch when closed. 3.) The Director of Maintenance or designee is responsible for on-going monitoring. Findings during monitoring will be submitted to QAPI committee for review. 4.) The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued compliance. 5.) Date of completion and compliance: October 17th, 2022	

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	Spring Hall corridor failed to positively latch when tested. 5) At 4:32 PM, fire-rated door from Main Dining Room to Kitchen failed to positively latch when tested. These findings were confirmed in interview with the facility Maintenance Supervisor at the time of observation.			
K0511 SS= E	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 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical wiring and equipment complies with NFPA 70, as required by 19.5.1.1, 9.1.1 and 9.1.2. This deficient practice could affect more than a limited number of facility occupants in the event of a fire. Findings Include: On September 20, 2022 the following deficiencies were observed at the times and locations indicated: 1) At 2:01 PM, large electrical panel door left open with combustibles stored within 3' of the same in Dry Storage. 2) At 2:43 PM, 120-volt relay in Maintenance	K0511		

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	Office missing its required cover. 3) At 2:59 PM, combustible stock items stored within 3' of electrical panel in the main Boiler room. 3) At 3:08 PM, electrical switch panel on wall in Laundry required cover panel broken off. 4) At 4:15 PM, combustible stock items in the form of several wheel chairs stored within 3' of open electrical panel in the Electrical Room. These findings were confirmed in interview with the facility Maintenance Supervisor at the time of observation.			
K0711 SS= E	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 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure there is a written plan for the protection of all residents and for their evacuation in the event of an emergency, employees are periodically instructed in their	K0711	1.) The Emergency Plan / Disaster Manuals have been updated and Dietary staff have been in-serviced on proper procedure for a basic fire scenario involving a grease fire. 2.) All emergency plan / disaster manuals have been reviewed to ensure accuracy and current recorded updates. All staff have been re-educated on fire plan with emphasis on dietary staff and grease fires. 3.) The Inservice Director or designee is responsible for on-going monitoring. Findings during monitoring will be submitted to QAPI committee for review. 4.) The Inservice Director is responsible for continued monitoring. The Administrator is responsible for continued compliance. 5.) Date of completion and compliance: October 17th, 2022	10/17/2022

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	duties under the plan, the plan is readily available, addresses the basic response required by staff and provides all components as required by 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2 and 19.7.2.3. This deficient practice could affect more than a limited number of facility occupants in the event of a fire. Findings Include: 1) On September 20, 2022 at 10:40 AM, record review revealed the facility failed to to provide updated Emergency Plan/Disaster Manuals to the the Summer Nurse Station as required. The last recorded update in that manual was 8/12/2019. 2) On September 20, 2022 at 2:28 PM, observation and interview revealed the on-duty Dietary Kitchen Staff could not provide accurate knowledge nor demonstrate proper procedure commensurate with their published Fire Safety Plan when given a basic fire scenario involving a grease fire from the surveyor. These findings were confirmed in interview with the facility Maintenance Supervisor at the time of record review and /or observation.			

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	824350	A. BUILDING _____ B. WING _____	**9/20/2022**

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K0712 SS= F	Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions, are held at unexpected times under varying circumstances, conducted at least quarterly on each shift and responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership as required by 19.7.1.4 through 19.7.1.7. This deficient practice could affect all facility occupants in the event of a fire. Findings Include: On September 20, 2022 at 11:43 AM, record review revealed the facility failed to conduct their required fire drill at "...unexpected time and under varying conditions" for the 4th Quarter, 1st Shift 2021 to present. The drills for the 1st Shifts were as follows: 4th Quarter 2021 at 10:33 AM, 1st Quarter 2022 at 10:30 AM, 2nd Quarter 2022 at 9:55 AM, and 3rd Quarter 2022 at 10:30 AM. These findings were confirmed in interview with the facility Maintenance Supervisor at the time of record review.	K0712	1.) All future fire drills will be held at unexpected times under varying circumstances, conducted at least quarterly on each shift. 2.) The Maintenance Director has been re-educated on requirement for fire drills to be conducted at varied times and with varied circumstances. 3.) The Director of Maintenance or designee is responsible for on-going monitoring. Findings during monitoring will be submitted to QAPI committee for review. 4.) The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued compliance. 5.) Date of completion and compliance: October 17th, 2022	10/17/2022

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K0761 SS= D	Maintenance, Inspection & Testing - Doors Maintenance, Inspection & 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) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to inspect and test annually in accordance with NFPA 101, 19.7.6, 8.3.3.1 and NFPA 80, Standard for Fire Doors and Other Opening Protectives 5.2, 5.2.3. 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. This deficient practice could affect an isolated number of facility occupants in the event of a fire. Findings Include: On September 20, 2022 at 1:58 PM, observation revealed the fire rating tag on fire-rated door frame to Dietary Dry Storage was obscured by paint and unreadable.	K0761	1.) The fire rating tag on the fire-rated door frame to Dietary Dry Storage has been cleared of paint and is readable. 2.) The maintenance staff have been re-educated on fire-rated doors to ensure tags remain unobscured. 3.) The Director of Maintenance or designee is responsible for on-going monitoring. Findings during monitoring will be submitted to QAPI committee for review. 4.) The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued compliance. 5.) Date of completion and compliance: October 17th, 2022	10/17/2022

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	These findings were confirmed in interview with the facility Maintenance Supervisor at the time of observation.			
K0918 SS= F	Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent 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) This REQUIREMENT is not met as	K0918	1.) The Annual Servicing for the installed emergency power generator and the 90 minute load bank have been completed and / or scheduled with PM technology. 2.) The Maintenance Director was re-educated on the requirement as well as maintaining proper documentation. 3.) The Director of Maintenance or designee is responsible for on-going monitoring. Findings during monitoring will be submitted to QAPI committee for review. 4.) The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued compliance. 5.) Date of completion and compliance: October 17th, 2022	10/17/2022

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	evidenced by: Based on record review and interview, the facility failed to ensure generators or other alternative power sources and associated equipment is capable of supplying service within 10 seconds, is maintained, inspected, tested and exercised in accordance with NFPA 110, and records are readily available as required by 6.4.4, 6.5.4 and 6.6.4 of NFPA 99, NFPA 110, NFPA 111 and 700.10 of NFPA 70. This deficient practice could affect all facility occupants in the event of a loss of commercial power. Findings Include: On September 20, 2022 at 12:05 PM, record review revealed the facility failed to provide evidence of the required "Annual Servicing Date" for their installed emergency power generator for 2021. Additionally, there was no evidence presented of the required "90-Minute Load Bank Date" for 2021 and 2020. These findings were confirmed in interview with the facility Maintenance Director at the time of record review.			
K0923 SS= E	Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet	K0923	1.) The carbon dioxide cylinders in the main kitchen by the beverage supply area have been secured. 2.) Dietary staff have been re-educated on proper storage of cylinders. 3.) The Dietary Manager or designee is responsible for on-going monitoring. Findings during monitoring will be submitted to QAPI committee for review. 4.) The Dietary Manager is responsible for continued monitoring. The Administrator is responsible for continued compliance. 5.) Date of completion and compliance:	10/17/2022

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	(5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure storage of nonflammable gasses meet all requirements of 11.3.1 through 11.3.4 and 11.6.5 of NFPA 99. This deficient practice could affect more than a limited number of facility occupants in the event of a fire, cylinder damage or rupture from damage. Findings Include: On September 20, 2022 at 2:22 PM, observation revealed four 24.5 lbs carbon dioxide cylinders		October 17th, 2022	

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	were unsecured on the floor in the beverage supply area of the main Kitchen. These findings were confirmed in interview with the facility Maintenance Supervisor at the time of observation.			