STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	414290	A. BUILDING ______ B. WING ______	**11/18/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKLD BELTLINE	**2320 E BELTLINE SE GRAND RAPIDS, MI 49546**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000 SS=	Initial Comments On November 18, 2022, An Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, SKLD Beltline was found to be not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73. The facility has 182 certified beds. At the time of the survey the census was 138. An exit conference was held at the conclusion of the survey. The results of the inspection were discussed with the Administrator and the Maintenance Director. The requirement at 42 CFR, subpart 483.73 is not met as evidenced by:	E0000		
E0039 SS= F	EP Testing Requirements §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), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, ""Organizations"" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (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	E0039	Element One On 12/16/2022, the safety committee and other departments completed a tabletop disaster drill with an active shooter/intruder scenario. Element Two All residents have the potential to be affected by this practice. Element Three The Plant Operations Manager re-educated the Maintenance Director to ensure tabletop disaster plan activities are completed with the interdisciplinary team annually on 12/12/2022. Element Four The Administrator/designee will conduct random audits of the facility's emergency preparedness for three months until substantial compliance has been attained and maintained to ensure the review and updating	12/19/2022

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

Electronically Signed — 12/16/2022

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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	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. (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. (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. *[For Hospices at 418.113(d):] (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: (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 an individual facility based functional exercise every 2 years; or (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		of the Emergency Management Plan is in action. The results will be presented to the QAA committee for review and consideration of further corrective actions. Element Five The Administrator will ensure substantial compliance is attained through this plan of correction by 12/19/2022 and for sustained compliance after that.	

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	individual facility-based functional exercise following the onset of the emergency event. (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: (A) A second full-scale exercise that is community-based or 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. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice 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; or (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. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (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			

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	messages, or prepared questions designed to challenge an emergency plan. (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. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (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: (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. (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. (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. *[For PACE at §460.84(d):] (2) Testing. The			

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	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 accessible, conduct an annual individual, facility-based functional exercise; or (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. (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: (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. (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. *[For LTC Facilities at §483.73(d):] (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: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a			

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	community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (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. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (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. (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. *[For ICF/IIDs at §483.475(d)]: (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: (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 ICF/IID experiences an actual natural or man-made emergency that requires 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			

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	emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an 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. (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. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a 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 every 2 years; or. (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, facility based functional exercise following the onset of the emergency event. (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: (A) A second full-scale exercise that is community-based or an 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			

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	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. (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. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (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. (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. *[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			

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all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.
This REQUIREMENT is not met as evidenced by:

Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The facility must participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the facility-based experiences an actual natural or man-made emergency that requires activation of the emergency plan, the facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. The facility must conduct an additional exercise that may include but is not limited to a second full-scale exercise that is community-based or individual, facility-based. A tabletop exercise that includes 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. The facility must analyze the response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the facility's emergency plan, as needed. This deficient practice could affect all occupants in the event staff are not properly trained in approved emergency procedures.

Findings Include:

On 11/18/22 during the review of the facility Emergency Preparedness Manual between 11:00am and 2:30pm, there was no

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	documentation provided for the annual tabletop or community-based exercise as required in 42 CFR, subpart 483.73(d)(2). These findings were confirmed during an interview with the Maintenance #1 at the time the records were reviewed.			
K0000 SS=	INITIAL COMMENTS On November 18, 2022, A Life Safety Recertification Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, SKLD Beltline was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire and the applicable provisions of the 2012 Edition of the National Fire Protection Agency (NFPA) 101, Life Safety Code and the 2012 Edition of NFPA 99, Health Care Facilities Code. The facility is a single story building of type II (000) construction built in 1961, with additions in 1968, 1971 and 1993. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 182 certified beds. At the time of the survey the census was 138 . An exit conference was held at the conclusion of the survey. The results of the inspection were discussed with the Administrator and the Maintenance Director. The requirement at 42 CFR, subpart 483.90(a) is not met as evidenced by:	K0000		

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K0211 SS= F	Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exit access corridors were clear of all obstructions in accordance with LSC Section 19.2.2 and Chapter 7. This deficient practice could potentially affect all occupants of the facility in the event of delayed egress because of obstructions during an emergency evacuation. Findings include: On 11/18/22 at 3:48pm, observation revealed there were Isolation carts in corridors without wheels which is a violation of LSC 19.2.3.4(4). These findings were confirmed during an interview with Maintenance #1 at the time observed.	K0211	Element One The isolation carts without wheels were removed from service. Element two All residents have the potential to be affected by this practice. Hallways audited and removed obstacles that did not have wheels on them. Element Three The administrator/designee re-educated all staff to ensure items that do not have wheels are not in corridors when not in use. All staff will be educated by 12/19/2022 or by the beginning of their next scheduled shift. Element Four The Administrator/designee will conduct random audits of the facility corridors weekly, times four weeks, and monthly times three months or until substantial compliance has been attained and maintained to ensure the halls are free of obstacles that are not on wheels. The results will be presented to the QAA committee for review and consideration of further corrective actions. Element Five The Administrator will ensure substantial compliance is attained through this plan of correction by 12/19/2022 and for sustained compliance after that.	12/19/2022
K0321 SS= E	Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-	K0321	Element One Room 405 has a self-close mechanism with a latch and lock as of 11/21/2022. Element Two All residents have the potential to be affected by this practice. Rooms identified for storing equipment have a self-close mechanism with a latch and lock in place. Element Three The Plant Operations Manager re-educated the Maintenance Director to ensure that	12/19/2022

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	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) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide for the protection of hazardous areas in accordance with LSC Section 19.3.2.1. This deficient practice could potentially affect 15 occupants of the facility in the event of a fire not being contained to the hazardous area. Findings include: On 11/18/22 at 2:48pm, observation revealed resident room 405 was being use for equipment storage. The door did not self-close to a positive latch and did not lock against unauthorized entry as required by LSC 8.4.5.3. These findings were confirmed during an interview with Maintenance #1 at the time observed.		rooms used to store equipment have a self-close mechanism with a latch and lock on 12/12/2022. Element Four The Administrator/designee will conduct random audits of the construction areas weekly, times four weeks, and monthly, times three months, or until substantial compliance has been attained and maintained to ensure the review and updating of the Emergency Management Plan is completed. The results will be presented to the QAA committee for review and consideration of further corrective actions. Element Five The Administrator will ensure substantial compliance is attained through this plan of correction by 12/19/2022 and for sustained compliance after that.	
K0324 SS= F	Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with	K0324	Element One The shelf on the range oven obstructing the	12/19/2022

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	414290	A. BUILDING ______ B. WING ______	11/18/2022

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	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 This REQUIREMENT is not met as evidenced by: Based on observation, records review and interview, the facility failed to protect cooking facilities in accordance with LSC Section 19.3.2.5 and NFPA 96. This deficient practice could potentially affect the in the event of This deficient practice could affect all occupants in the event of a gas leak and/or fire in the kitchen. Findings include: 1. On 11/18/22, during the review of facility records between 11:00 am and 2:30pm, there was no current documentation provided for the monthly "owners " hood inspection as required in NFPA 17A, 7.2. Last record was September 2021. 2. On 11/18/22 at 3:28pm, observation revealed the shelf attached to the Kitchen stove would		fire suppression systems was removed on 12/13/2022. Additionally, the non-commercial grade gas line attached to the convection ovens was replaced with a commercial gas line on 12/16/2022. Element Two All residents have the potential to be affected by this practice. Element Three The Plant Operations Manager re-educated the Maintenance Director to ensure range hood inspections were completed monthly, hence logged for record keeping on 12/12/2022. Element Four The Administrator/designee will conduct random audits of the logs being kept of the monthly inspection monthly times for three months or until substantial compliance has been attained and maintained to ensure that these inspections are being conducted correctly. The results will be presented to the QAA committee for review and consideration of further corrective actions. Element Five The Administrator will ensure substantial compliance is attained through this plan of correction by 12/19/2022 and for sustained compliance after that.	

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	cause an obstruction to the suppression nozzles if activated which violates NFPA 96, 10.2.7.3. 3. On 11/18/22 at 3:30pm, observation revealed the gas supply line for the Kitchen Vulcan Convection Oven was not commercial grade piping as required in NFPA 54, 9.6.1. These findings were confirmed during an interview with Maintenance #1 at the time observed and reviewed.			

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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 records review and interview the facility failed to provide written documentation regarding fire drills in accordance with LSC Section 19.7.1. This deficient practice could potentially affect all occupants of the facility if staff are not properly trained in approved emergency procedures. Findings include: On 11/18/22 during the review of facility records between 11:00am and 2:30pm,, there was no documentation provided for fire drills being conducted on the second shift in the first quarter or on the third shift in the third quarter. The drills were also not conducted throughout the shifts under varying conditions as required in LSC 19.7.1.6. These findings were confirmed during an interview with the Maintenance #1 at the time the records were reviewed.	K0712	Element One The Maintenance Director has performed drills on all shifts as of 12/19/2022. Element Two All residents have the potential to be affected by this practice. Element Three The Plant Operations Manager re-educated the Maintenance Director about the importance of conducting unannounced staff drills using the emergency procedures on 12/12/2022 and ensuring documentation. Element Four The Administrator/designee will conduct random audits of the logs being kept off the quarterly fire drills every three months or until substantial compliance has been attained and maintained to ensure that these drills are being conducted correctly and on time. The results will be presented to the QAA committee for review and consideration of further corrective actions. Element Five The Administrator will ensure substantial compliance is attained through this plan of correction by 12/19/2022 and for sustained compliance after that.	12/19/2022
K0761 SS= F	Maintenance, Inspection & Testing - Doors Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80,	K0761	Element One All fire door inspections were completed on 11/30/2022 and recorded on the proper forms. Element Two	12/19/2022

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	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 records review and interview, it was determined that the facility did not conduct the required annual inspection and testing of fire doors assemblies in accordance with LSC Section 8.3.3.1 and NFPA 80. This deficient practice could potentially affect all occupants of the facility. A delay in exiting the facility could increase occupant exposure to a hazardous condition. Findings include: On 11/18/22 during the review of facility records between 11:00am and 2:30pm, there was no current documentation provided for the annual testing of fire doors as required in NFPA 80 5.2.1. Last record was March 2021. These findings were confirmed during an interview with the Maintenance #1 at the time the records were reviewed.		All residents have the potential to be affected by this practice. Element Three The Plant Operations Manager re-educated the Maintenance Director to ensure monthly fire door inspections are completed. Element Four The Administrator/designee will conduct random audits of the inspection logs until substantial compliance has been attained and maintained to ensure that these drills are performed correctly and on time. The results will be presented to the QAA committee for review and consideration of further corrective actions. Element Five The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 12/19/2022 and for sustained compliance after that.	
K0918 SS= F	Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The	K0918	Element One Both generators had fuel samples drawn and taken to the lab for testing on 12/13/2022. The	12/19/2022

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	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 evidenced by: Based on records review and interview, the facility failed to provide the generator is maintained in accordance with NFPA 110. This deficient practice could potentially affect all occupants of the facility in the event of a		results are being kept in the Life Safety Manual. Element Two All residents have the potential to be affected by this practice. Element Three The Plant Operations Manager completed re-education with the Maintenance Director to ensure the fuel sampling of the generators is conducted annually. Element Four The Administrator/designee will conduct random audits of the logs being kept of the test until substantial compliance has been attained and maintained to ensure that these drills are performed correctly and on time. The results of the audits will be presented to the QAA Committee for review and consideration of further corrective actions. Element Five The Administrator will ensure substantial compliance is attained through this plan of correction by 12/19/2022 and for sustained compliance after that.	

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	generator failure due to a lack of maintenance. Findings include: On 11/18/22 during the review of facility records between 11:00 am and 2:30pm, there was no documentation available for the annual emergency generator fuel sample testing per ASTM standards as required in NFPA 110, 8.3.8. These findings were confirmed during an interview with the Maintenance #1 at the time the records were reviewed.			