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 ______	**1/11/2024**

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 January 17, 2023, 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 in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		
K0000 SS=	INITIAL COMMENTS On January 17, 2024, 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 482.90(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 one story building of type II (000) construction, built in 1961, with additions in 1968, 1971 and 1973. 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 126.	K0000		
K0111	Building Rehabilitation Building Rehabilitation Repair, Renovation, Modification, or	K0111	K111 Building Rehabilitation CFR(s): NFPA 101	2/6/2024

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

Electronically Signed | 02/03/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 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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SS= E	Reconstruction Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: * Requirements of Chapter 18 and 19 * Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 Change of Use or Change of Occupancy Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7) Additions Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a 2-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2-hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a building undergoing repair, renovation, modification or reconstruction complies with the following: Requirements of Chapter 18 and 19; and Requirements of the applicable Sections 43.3, 43.4, 43.5 and 43.6, as required by 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1.		LSC 4.6.10.1 and 4.6.10.2 No residents were Identified. All residents can be affected by this practice. The facility has removed a resident exit corridor barrier located at 200 Hall. The administrator re-educated the Maintenance Director to ensure that when undergoing an addition, it shall comply with the requirements of Section 43.8. Where the building has a common wall with a nonconforming structure, the shared wall with a fire barrier has at least a 2-hour fire-resistance rating constructed of materials as required for the addition. The Administrator/designee will complete weekly audits for four weeks. Then, every two weeks for a month to ensure substantial compliance, thus ensuring when undergoing an addition, the facility complies with the requirements of Section 43.8. Therefore, the facility has a common wall with a nonconforming building; the shared has a fire barrier with at least a 2-hour fire-resistance rating constructed of materials as required for the addition. Any concerns will be addressed immediately. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will ensure substantial compliance is attained through this plan of correction by 2/6/2024 and for sustained compliance after that.	

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	Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2, 4.6.7, 4.6.11, as required by 43.1.2.2. Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2 hour fire resistance rating as required by 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3 as required by 43.8. This deficient practice could potentially affect 8 occupants and staff in the event an emergency evacuation was required from the area and egress was not maintained during temporary construction and modification of a section or portion of the building. Findings Include: On 1/17/24 at approximately 10:30 AM observation revealed the resident exit corridor located at 200 hall contained a non approved temporary obstruction that limits the path of egress to exit discharge in one direction. The temporary barrier was on wheels and chained to the railings of the corridor walls. The barrier failed to meet the construction requirements and ratings for temporary walls and doors as well as limits egress during construction and renovations of rooms. As required by 4.6.10.1 and 4.6.10.2.			

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K0271 SS= E	Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure exit discharge was arranged in accordance with 7.7, provides a level walking surface in accordance with 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface as required by 18.2.7, 19.2.7. This deficient practice could potentially affect occupants, staff and visitors in the event an emergency evacuation from the area is required and the walkway to a public way is obstructed by a snow and icy surface. Findings Include: 1. On 1/17/24 at approximately 10:40 AM, observation revealed the side walk leading to a public way located outside the 600 hall low exit door was obstructed by snow and ice creating a non level accessible surface. This finding was confirmed by interview with the facility Maintenance Director at the time of observation. As required by 7.7 2. On 1/17/24 at approximately 10:57 AM, observation revealed the sidewalk leading to a public way located outside 600 hall high exit door was obstructed by snow, ice and a dumpster.	K0271	K271 Discharge from Exits CFR(s): NFPA 101 LSC 7.7 No residents were identified. All residents can be affected by this practice. The facility cleared the sidewalk from snow and ice, leading to the public way outside the 600-hall low exit door. The facility has removed snow, ice, and the dumpster outside 600 Hall's high exit door. The Administrator re-educated the Maintenance Director regarding the exit discharge arranged by provisions 7.7 to ensure there is a level walking surface meeting provisions 7.1.7 concerning changes in elevation and being maintained free of obstructions. Additionally, the exit discharge shall be a hard-packed all-weather travel surface. The administrator/designee will audit for four months to ensure the exit discharge meets provisions in accordance with 7.7, providing a level walking surface meeting provisions 7.1.7 concerning changes in elevation and maintaining it free of obstructions. Additionally, the exit discharge shall be a hard-packed all-weather travel surface. Any concerns identified will be addressed promptly. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will ensure substantial	2/6/2024

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			compliance is attained through this plan of correction by 2/6/2024 and for sustained compliance after that.	
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-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 Hazardous areas 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	K0321	K321 Hazardous areas- enclosure CFR(s): NFPA 101 LSC 8.7.13 No residents were identified. All residents can be affected by this practice. The facility removed the extension code at 500 Hall, room #503. The motorized is now charged in an outlet outside the room. The facility has repaired the door lock to the laundry service from penetrations surrounding the door lock. The administrator re-educated the Maintenance Director to ensure motorized wheelchairs and doors have no penetration surrounding the locks. Hence, 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. The Administrator/Designee will conduct weekly audits for four weeks and monthly until substantial compliance is reached, ensuring motorized wheelchairs and doors have no penetration surrounding the locks. Furthermore, to ensure that 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. Any concerns identified will be addressed immediately.	2/6/2024

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	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. This deficient practice could potentially affect occupants, staff and visitors within the room and the smoke compartment in the event of **a** fire emergency within the room as a result of charging wheel chair batteries in the room**.** Findings Include: 1. On 1/17/24 at approximately 9:25 AM, observation revealed wheel chair batteries being charged within the residents room located at 500 hall room # 503. This surveyor observed an extension cord routed from the outlet near the residents bed to the wheel chair. This finding was confirmed by interview with the Maintenance Director and resident at the time of observation. As required by 8.7.1.3 2. On 1/17/24 at approximately 9:52 AM, observation revealed penetrations surrounding the door lock on the door located at the laundry service hall.		The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will ensure substantial compliance is attained through this plan of correction by 2/6/2024 and for sustained compliance after that.	
K0353 SS= F	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	K0353	K353 Sprinkler system- Maintenance and Testing CFR(s): NFPA 101 NFPA 25 LSC: 5.2.1 and 9.7.5 No residents were identified. All residents can be affected by this practice. The facility has placed escutcheon plates on the sprinkler head at 400 hall storage, breakroom, dishwashing area in the central	2/6/2024

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	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 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 potentially affect all occupants and staff in the event the fire sprinkler system fails to operate as designed as a result of parts of the sprinkler missing or displaced in various locations within the building at the time of a fire. Findings Include: 1. On 1/17/24 at approximately 9:33 AM, observation revealed the sprinkler head located at 400 hall storage and breakroom was without a sprinkler escutcheon plate. This finding was confirmed by interview with the facility Maintenance Director at the time of observation. As required by NFPA 25 5.2.1 and 9.7.5 2. On 1/17/24 at approximately 9:46 AM, observation revealed the sprinkler head near the dishwashing area located in the main kitchen was missing an escutcheon plate. 3. On 1/17/24 at approximately 10:47 AM, observation revealed a sprinkler head located at 600 hall dining was missing an escutcheon plate.		kitchen, and 600 hall dining. The Administrator re-educated the Maintenance Director to ensure every sprinkler has escutcheon plates. Furthermore, ensure the automatic sprinkler and standpipe systems are inspected, tested, and maintained according to NFPA 25 and that records are readily available as required by 9.7.5, 9.7.7, 9.7.8, and NFPA 25. The Administrator/Designee will perform monthly audits x4 months to ensure every sprinkler has escutcheon plates. Furthermore, ensure the automatic sprinkler and standpipe systems are inspected, tested, and maintained according to NFPA 25 and that records are readily available as required by 9.7.5, 9.7.7, 9.7.8, and NFPA 25. Hence, any concerns will be addressed immediately. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 2/6/2024 and for sustained compliance after that.	

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	4. On 1/17/24 at approximately 11:15 AM, observation revealed the sprinkler head above the cross corridor doors located at station one and 300 hall was missing an escutcheon plate.			
K0363 SS= E	Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire	K0363	K363 Corridors- Doors CFR(s): 403, 418,482, 483, 485 LSC 19.3.6.3 No residents were identified. All residents can be affected by this practice. The facility has repaired room #506 at 500-hall, room #513 at 500-hall, and the door at the housekeeper's office at 100-hall office/storage. As evidenced by the doors closing and positively latching. The Administrator/Designee and the maintenance director were re-educated to ensure doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are 13/4 inch solid-bonded core wood or capable of resisting the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed as required by 19.3.6.3 and 42 CFR 403, 418, 460, 482, 483, and 485. The Administrator/Designee will perform monthly audits every four months to ensure that doors protect corridor openings, the doors close, and positively latch until substantial compliance is accomplished. Any concerns will be immediately addressed. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will be responsible for	2/6/2024

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	protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure doors protecting corridor openings in other than required enclosures of vertical openings, exits or hazardous areas are 1 3/4 inch solid-bonded core wood or capable of resisting the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed as required by 19.3.6.3, and 42 CFR 403, 418, 460, 482, 483 and 485. There is no impediment to the closing of doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinkler compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. This deficient practice could potentially affect occupants within the smoke compartment in the event the door fails to prevent the passage of smoke at the time of an fire emergency. . Findings Include:		assuring substantial compliance is attained through this plan of correction by 2/6/2024 and for sustained compliance after that.	

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	1. On 1/17/24 at approximately 9:12 AM, observation revealed the door at room #506 located at 500 hall failed to completely close and positive latch upon testing. This finding was confirmed by interview with the facility Maintenance Director at the time of observation. As required by 19.3.6.3 2. On 1/17/24 at approximately 9:22 AM, observation revealed the door at room # 513 located at 500 hall failed to positive latch upon testing. 3. On 1/17/24 at approximately 10:11 AM, observation revealed the door at house keepers office located at 100 hall office/storage failed to positive latch upon testing.			
K0374 SS= E	Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure doors in smoke barriers are 1-3/4 inch solid bonded wood-core doors or construction that resists fire for 20 minutes, are self-closing or automatic-closing and provide a	K0374	K374 Subdivision of Building Spaces-Smoke Barrier CFR(s): NFPA 101 LSC 19.3.7.8 No residents were identified. All residents could be affected by the deficient practice. The facility has repaired the cross-corridor smoke doors at 200 Hall Station One, Med-bridge, and the administrator, as evidenced by the doors closing upon testing. The Administrator re-educated the Maintenance Director to ensure doors in smoke barriers that are 1-3/4-inch solid bonded wood-core doors or construction that resists fire for 20 minutes are self-closing or automatic-closing and provide a maximum width of 32 inches as required by19.3.7.6, 18.3.7.8 and 19.3.7.9.	2/6/2024

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SKLD BELTLINE	**2320 E BELTLINE SE** **GRAND RAPIDS, MI 49546**

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	minimum width of 32 inches as required by 19.3.7.6, 18.3.7.8 and 19.3.7.9. This deficient practice could potentially affect occupants staff and visitors within the smoke compartments in the event the smoke doors failed to close to prevent the passage of smoke from one smoke compartment to the next at the time of an fire emergency. Findings Include: 1. On 1/17/24 at approximately 10:23 AM, observation revealed the cross corridor smoke doors located at 200 hall station one failed to close upon testing. This finding was confirmed by interview with the facility Maintenance Director at the time of observation. As required by 19.3.7.8 2. On 1/17/24 at approximately 11:20 AM, observation revealed the cross corridor smoke doors located at med bridge and administration failed to close upon testing.		The Administrator/designee will audit cross-corridor smoke doors weekly x4 weeks and monthly until substantial compliance has been reached. To ensure doors in smoke barriers that are 1-3/4-inch solid bonded wood-core doors or construction that resists fire for 20 minutes are self-closing or automatic-closing and provide a maximum width of 32 inches as required by19.3.7.6, 18.3.7.8 and 19.3.7.9. Any concerns will be addressed immediately. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will ensure substantial compliance is attained through this plan of correction by 2/6/2024 and for sustained compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 equipment using gas or gas-related piping complies with NFPA 54, and 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 potentially affect occupants and staff within the smoke compartment in the event an emergency electrical shut down at the breaker panel is required for the area to prevent injury,electrocution or a fire. Findings Include: On 1/17/24 at approximately 10:51 AM, observation revealed the electrical panel in the environmental storage room located at 600 high was obstructed by a cleaning cart and could not be immediately accessed. this finding was confirmed by interview with the facility Maintenance Director at the time of observation. As required by 9.1.2	K0511	K511 Utilities- Gas and Electric CFR(s): NFPA 70 LSC 9.1.2 No residents were identified. All residents can be affected by this practice. The facility has removed the cleaning cart that was obstructing the electrical panel in the environmental storage room located 600 high to ensure immediate access. The administrator re-educated the housekeeping personnel to ensure that cleaning carts in the environmental storage rooms do not block the electrical panel. Furthermore, the maintenance director was re-directed to ensure equipment using gas or gas-related piping complies with NFPA 54 and electrical wiring and equipment complies with 70, as required by 19.5.1.1, 9.1.1, and 9.1.2. The administrator/Designee will conduct random audits weekly for four weeks and monthly until substantial compliance has been reached; thus, any concerns identified regarding using equipment using gas or related piping comply with NFPA 70. Hence, any problems will be addressed immediately. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will ensure substantial compliance is attained through this plan of correction by 2/6/2024 and for sustained compliance.	2/6/2024
	Electrical Systems - Essential Electric Syste	K0918	K918- Electrical Systems- Essential Electric	2/6/2024

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K0918 SS= F	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 evidenced by: Based on record review and interview, the facility failed to ensure generators or other alternative power sources and associated equipment is		System CFR(s): NFPA 110 LSC 8.3.7 No residents were identified. All residents can be affected by this practice. The facility obtained a generator fuel sample test on 1/31/2024; hence, it has documentation to support fuel sample testing. The Administrator/Designee re-educated the Maintenance Director to ensure generators or other alternative power sources and associated equipment can supply service within 10 seconds and are maintained, inspected, tested, and exercised by NFPA 110. 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. The Administrator/designee will audit the facility fuel generator at least every ten months to ensure generator fuel sample testing is completed in less than 12 months from 1/31/2024, thus guaranteeing compliance as indicated by documentation. Any concerns will be addressed immediately. . The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will ensure substantial compliance is attained through this plan of correction by 2/6/2024 and for sustained compliance.	

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	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 potentially affect all occupants in the event the facility diesel fuel generator failed as a result of contaminated fuel due to no annual fuel sample testing. Findings Include: On 1/17/24 between 2:30 pm and 3:30 pm, record review revealed the facility failed to provide documentation of the required annual fuel sample testing for the year 2023. Records indicate the last fuel sample testing was completed on 12/13/22. This finding was confirmed by interview with the facility Maintenance Director at the time of observation. As required by NFPA 110, 8.3.7			
K0920 SS= E	Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a	K0920	K920- Electrical Equipment- Power Cords and Extension Cords CFR(s): NFPAc99 LSC: 10.2.3.6 No residents were identified. All residents can be affected by this practice. The facility removed two extension cords that were not in use at 500 Hall, room # 502. The Administrator re-educated the Maintenance Director on ensuring extension cords are not used as a substitute for a structure's fixed wiring. Additionally, extension cords used temporarily are removed immediately upon completion of the purpose they were installed and meet the conditions of 10.2.4.	2/6/2024

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	structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure power strips are listed for the area in which they are used as required by 10.2.3.6 of NFPA 99, 400-8 of NFPA 70 and TIA 12-5, and extension cords are placed in use only temporarily as required by 10.2.4 of NFPA 99 and 590.3(D) of NFPA 70. This deficient practice could potentially affect occupants and staff within the smoke compartment in the event of an electrical fire as a result of non approved use of electrical equipment. Findings Include: 1. On 1/17/24 at approximately 9:10 AM, observation revealed two extension cords in use located at 500 hall room # 502. This finding was confirmed by interview with the facility Maintenance Director at the time of observation. As required by NFPA 99 10.2.3.6 2. On 1/17/24 at approximately 9:25 AM, observation revealed an extension cord in use charging a wheel chair located at 500 hall room # 503. This finding was confirmed by interview with the facility Maintenance Director at the time of observation.		The Administrator/Designee will audit residents' rooms weekly for four weeks and then monthly for two months to ensure extension cords are not used as a substitute for a structure's fixed wiring. Additionally, extension cords used temporarily are removed immediately upon completion of the purpose they were installed and meet the conditions of 10.2.4. Hence, audit until substantial compliance has been accomplished by continuing with audits. Any concerns will be addressed immediately. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will ensure substantial compliance is attained through this plan of correction by 2/6/2024 and for sustained compliance.	