| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 415064 | A. BUILDING _____ B. WING _____ | 12/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PAWTUCKET FALLS HEALTHCARE CENTER | 70 GILL AVENUE PAWTUCKET, RI 02861 |

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| F 000 | INITIAL COMMENTS<br><br>An off-hour recertification and complaint survey, ACTS reference number 98398, was conducted at Pawtucket Falls Healthcare Center Nursing Home on 12/08/2024 through 12/12/2024 to determine compliance with 42 C.F.R. Part 483, requirements for Long Term Care Facilities. A state licensure and emergency preparedness survey was also conducted at this facility.<br><br>Deficiencies were identified. | F 000 | This Plan of Correction is the center's credible allegation of compliance.<br><br>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on surveyor observation, record review, resident, and staff interview, it has been determined that the facility failed to ensure that assessments accurately reflect the residents' status for 1 of 1 resident reviewed relative to a fall with injury, Resident ID #75.<br><br>Findings are as follows:<br><br>Record review revealed Resident ID #75 was readmitted to the facility in September of 2024 with a diagnosis including, but not limited to, unspecified fracture of the lower end of the left radius (a long bone in the forearm that helps you move your arm and wrist).<br><br>Review of a Quarterly Minimum Data Set (MDS) Assessment dated 9/27/2024 revealed the resident has a Brief Interview for Mental Status | F 641 | F 641 Accuracy of Assessment<br><br>1.Resident #75's MDS has been reviewed and revised to reflect the 9/18/2024 fall with a significant injury and submitted on 12/12/24.<br><br>2.Residents who have experienced a fall with a significant injury have the potential to be affected by the same alleged deficiency.<br><br>3.MDS team members have been educated on the criteria for coding falls with significant injuries that occur during the assessment observation period.<br><br>4.Weekly audits x4 than monthly audits x3 will be conducted of changes to care, and condition of residents to ensure the facility policy and standards of practice is followed are compliance and results will be reviewed at QAPI meetings until substantial compliance is met.<br><br>5.The MDS/or DNS is responsible for compliance of this PoC. | 1/10/25 |

12/24/24

Facilities Regulation

Received
DEC 23 2024

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Linda B Cella | Administrator | 12/23/24 |

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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| F 641 | Continued From page 1<br>score of 14 out of 15 indicating intact cognitive function.<br><br>Record review of Residents ID #75's progress notes revealed the following:<br><br>- 9/18/2024 at 5:22 AM revealed the resident was found in a sitting position on the floor in his/her room and was complaining of pain to his/her left wrist with swelling noted.<br><br>- 9/18/2024 at 6:55 PM x-rays were completed at the facility and showed possible left wrist fracture.<br><br>- 9/19/2024 at 7:24 PM the resident presented with increased confusion, irregular cardiac rhythm and was sent out to the hospital.<br><br>- 9/24/2024 at 5:34 AM the resident was transported to the hospital on 9/19/2024 with a change in mental status and a left wrist fracture secondary to a fall. The resident returned to the facility on 9/23/2024 with a soft cast and instructions for non-weight bearing to his/her left upper extremity.<br><br>Record review of the residents's Quarterly MDS assessment dated 9/272024, section J, failed to reveal documentation of the above mentioned falls, as required.<br><br>During a surveyor interview on 12/10/2024 at 1:30 PM with Registered Nurse, Staff A, he revealed the MDS Assessment should have reflected the resident's fall sustained on 9/18/2024 and it did not.<br><br>Subsequent record review following the above interview with Staff A revealed, the resident's | F 641 | | |

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| F 641 | Continued From page 2<br>Quarterly MDS dated 9/27/2024 had been revised on 12/10/2024 to include the resident's fall on 9/18/2024. However, the revision did not include that the resident sustained an injury from the fall.<br><br>During a surveyor interview on 12/12/2024 at 10:08 AM with the resident, s/he revealed that the fracture to his/her left wrist was not an old injury as s/he had no issues with his/her wrist until after s/he fell on 9/18/2024.<br><br>During a surveyor interview on 12/11/2024 at 12:11 PM with the Director of Nursing Services she acknowledged that the MDS assessment was coded inaccurately, and she would have expected the MDS to accurately represent the resident status during the observation period. | F 641 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, it has been determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice relative to following physician's order for obtaining orthostatic blood pressure (a form of low blood pressure that happens when standing up from a sitting or lying down position) for 1 of 1 resident reviewed, Resident ID #76.<br><br>Findings are as follows: | F 658 | F 658Services provided meet Professional Standards<br><br>1.Resident #76 remains at the facility and has orthostatic blood pressure being monitored as ordered. Unless otherwise discontinued.<br><br>2.A facility wide audit was conducted to identify all residents with Physicians/NP orders for orthostatic BP monitoring. Audit revealed (zero) residents with similar orders.<br><br>3.Licensed Nursing staff will receive training/education on following physician orders and the documentation of orthostatic blood pressure monitoring.<br><br>4.Weekly audits x4 than monthly audits x3 will be conducted for all residents with orthostatic BP orders to ensure the facility policy and standards of practice is followed are compliance and results will be reviewed at QAPI meetings until substantial compliance is met. | 1/10/25 |

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| F 658 | Continued From page 3<br><br>According to Mosby's 4th Edition, Fundamentals of Nursing, page 314, states in part, "The physician is responsible for directing medical treatment. Nurses are obligated to follow physicians' orders unless they believe the orders are in error or would harm the clients."<br><br>According to Jensen's 4th Edition, "Nursing Health Assessment, A Clinical Judgement Approach" page 118 states in part, "Orthostatic vital signs are measured in patients to assess for a drop in blood pressure and heart rate with position changes...Assess BP [blood pressure] with patient supine [lying position] sitting, and then standing. The patient should rest supine for at least 2 minutes before the assessment of the baseline reading. Repeat measurements with the patient sitting and standing, wait 1-2 minutes after each position change to assess the readings..."<br><br>Record review revealed the resident was admitted to the facility in October of 2024 with diagnoses including, but not limited to, dementia and repeated falls.<br><br>Record review of a physician's order dated 10/12/2024 through 11/12/2024 and a new start date of 11/13/2024 through 11/19/2024, revealed an order to check the resident's orthostatic blood pressure two times a day, on the morning and evening shifts.<br><br>Record review of the November 2024 Medication Administration Record (MAR) failed to reveal evidence that orthostatic vital signs had been completed.<br><br>During a surveyor interview with the Director of | F 658 | 5.The Director of Nursing/or designee is responsible for compliance of this PoC. | |

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| F 658 | Continued From page 4<br>Nursing Services (DNS) on 12/12/2024 at 10:05 AM, she indicated that the orthostatic blood pressures were ordered due to the amount of recurrent falls that the resident had sustained. The DNS indicated that she would expect the staff to check and document the resident's orthostatic blood pressure, as ordered.<br><br>During a surveyor interview with Nurse Practitioner, Staff B, on 12/12/2024 at 11:24 AM, she indicated that she had ordered the orthostatic blood pressures to be obtained because the resident has complained of severe vertigo (a sudden internal or external spinning sensation, often triggered by moving your head too quickly) and it has resulted in the resident having multiple falls. Staff B indicated that she would expect the resident's orthostatic blood pressure to be obtained, as ordered. | F 658 | | |
| F 688 SS=E | Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)<br><br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with | F 688 | F 688Increase/Prevent Decrease in ROM/Mobility<br><br>1.Resident #13 remains at the facility and has devices in place as ordered to prevent and/or reduce the worsening of contractures.<br><br>2.Residents with ordered devices to prevent and/or reduce contracture development are potentially at risk for the same alleged deficient practice.<br><br>3.a) A facility audit of devices ordered to prevent and/or reduce the worsening of contractures was conducted to ensure.<br>b) Licensed nurses will be educated on ensuring resident specific devices are in place when signing the MAR/TAR. | 1/10/25 |

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| F 688 | Continued From page 5<br>the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:<br>Based on surveyor observation, record review, resident, and staff interview, it has been determined that the facility failed to ensure a resident with limited range of motion (ROM) receives appropriate treatment and services to increase ROM and/or to prevent further decrease in ROM for 1 of 2 residents reviewed with contractures, Resident ID #13.<br><br>Findings are as follows:<br><br>Review of the facility's policy titled "Splints/Orthotics/Prosthetics [medical devices used to assist when physical impairments or limitations are present]" states in part, "Residents will receive splint/orthotics/prosthetics as deemed appropriate by the physician and rehabilitation services...Nursing staff will apply/remove the designated splint/orthotics/prosthetic device during scheduled wearing times..."<br><br>Record review revealed the resident was readmitted to the facility in November of 2024 with diagnosis including, but not limited to, Parkinson disease (a progressive neurological disorder that causes nerve cells in the brain to die which affects movement including stiffness, and loss of balance).<br><br>Record review of a Quarterly Minimum Data Set (MDS) Assessment dated 11/14/2024 revealed a Brief Interview for Mental Status Score of 10 out of 15 indicating a moderate cognitive impairment.<br><br>Record review of a Quarterly MDS Assessment | F 688 | 4.Weekly audits x4 than monthly audits x3 will be conducted for all residents with contractures/ROM orders and care plan. Interventions will be maintained and updated to ensure that the facility policy and standards of practice are followed are compliance and results will be reviewed at QAPI meetings until substantial compliance is met.<br><br>5.The Director of Nursing/or designee is responsible for compliance of this PoC. | |

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| F 688 | Continued From page 6<br>dated 11/14/2024 revealed the resident has upper extremities impairments on both sides. Further review of this assessment revealed the resident is totally dependent on staff for all activities of daily living, including transfers, eating, dressing, toileting, and bed mobility.<br><br>Record review of a care plan with revision dates of 3/5/2024 and 6/12/2024 revealed the resident is at risk for a decline in physical function. Staff interventions include, but are not limited to, provide carrot (a device used to prevent contractures) to left hand and bilateral palm guards (devices that are used as a barrier between the fingers and the palm to prevent injury to the palm from severe finger contractures).<br><br>Record review revealed a physician's order initiated on 8/7/2023 to place the carrot in the resident's left hand every shift, as tolerated.<br><br>During surveyor observations of the resident on 12/10/2024 at 9:08 AM, 10:46 AM, 11:37 AM, and 2:01 PM, s/he was observed in bed with bilateral hands contracted and the carrot was not applied to his/her left hand, as ordered.<br><br>Further record review of the Treatment Administration Record for December 2024 revealed the order for the carrot was signed off by Licensed Practical Nurse (LPN), Staff C as being completed on 12/10/2024, although the carrot was not observed to be in his/her left hand. Additionally, the record failed to reveal evidence the resident had refused the carrot.<br><br>Additional surveyor observations on the following dates and times revealed that the bilateral palm | F 688 | | |

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| F 688 | Continued From page 7<br>guards were not applied as indicated in his/her care plan:<br><br>- 12/09/2024 9:48 AM<br>- 12/10/2024 9:08 AM<br>- 12/10/2024 10:46 AM<br>- 12/10/2024 11:20 AM<br>- 12/10/2024 11:37 AM<br>- 12/10/2024 02:01 PM<br>- 12/10/2024 03:01 PM<br>- 12/11/2024 08:15 AM<br>- 12/11/2024 09:59 AM<br><br>During a surveyor interview with the resident on 12/10/2024 at 2:05 PM, s/he indicated that s/he was not utilizing the carrot or bilateral palm guards and stated that s/he had not been offered these devices by the staff on this date.<br><br>During a surveyor interview with LPN, Staff C, on 12/11/2024 at 9:16 AM, she indicated that she is responsible for applying the carrot to the resident's left hand as ordered. She indicated that she was not aware that the resident should have been wearing bilateral palm guards. Additionally, Staff C could not provide evidence the resident was using the carrot as ordered though she had signed off the carrot was in place on 12/10/2024.<br><br>During a surveyor interview with the Director of Nursing Services (DNS) on 12/11/2024 at 11:47 AM, she could not provide evidence as to why the resident's bilateral contractures were not being addressed. The DNS indicated that she would expect the staff to apply the carrot to the resident's left hand as ordered and the bilateral palm guards as indicated in the care plan. Additionally, the DNS indicated that if the resident refuses either of these devices, the staff should | F 688 | | |

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| F 688 | Continued From page 8<br>document the refusals in the resident's record. | F 688 | | |
| F 698 SS=E | Dialysis<br>CFR(s): 483.25(l)<br><br>§483.25(l) Dialysis.<br>The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, resident, and staff interview, it has been determined that the facility failed to ensure that residents who require dialysis (a treatment that removes excess fluid, waste, and toxins from the blood when the kidneys are no longer functioning properly) receive such services, consistent with professional standards of practice for 1 of 2 residents reviewed for fluid restrictions, Resident ID #30.<br><br>Findings are as follows:<br><br>Record review of a facility policy titled "Fluid Restrictions" states in part, "...The fluid restriction breakdown should be documented in the Medication Administration Record (MAR), as well as dietary or tray card..."<br><br>Record review revealed the resident was admitted to the facility in July of 2024 with diagnoses including, but not limited to, end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant | F 698 | F 698 Dialysis<br><br>1.Resident # 30 remains at the facility and has his/her fluid restriction monitored and documented.<br><br>2.Residents with an ordered fluid restriction are potentially at risk for the same alleged deficient practice.<br><br>3.a) An audit will be conducted and update on all residents with fluid restrictions to ensure the fluid restriction is monitored and documented.<br>b) Nursing staff, activities aid and dietary staff will be educated on the facility policy and expectations for monitoring and documenting on paper and PCC on residents with an ordered fluid restriction.<br><br>4.Weekly audits x4 than monthly audits x3 will be conducted for all residents with fluid restriction orders to ensure that the facility policy and standards of practice are followed, and results will be reviewed at QAPI meetings until substantial compliance is met.<br><br>5.The Registered Dietician/or DNS is responsible for compliance of this PoC. | 1/10/25 |

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| F 698 | Continued From page 9<br>to maintain life) and cerebral infarction (a condition when blood flow to the brain is blocked, causing brain cells to die).<br><br>Further record review revealed the resident receives outpatient dialysis three times a week on Monday, Wednesday, and Fridays.<br><br>Review of a Quarterly Minimum Data Set Assessment dated 9/17/2024, revealed the resident has a Brief Interview for Mental Status score of 13 out of 15 indicating intact cognitive function.<br><br>Record review of a care plan revised on 12/8/2024 included an intervention for fluid restrictions per the physician's order.<br><br>Record review revealed the resident has a physician's order that was initiated on 10/25/2024 for a fluid restriction of 1000 milliliters (mL) daily.<br><br>Record review of the Medication Administration Records (MAR) for November 2024 and December 2024 failed to reveal evidence that the resident's 1000 mL daily fluid restriction was documented per the facility's policy.<br><br>During a surveyor observation of the resident on 12/9/2024 at approximately 10:00 AM, revealed s/he was waiting to be picked up for dialysis and had received a 240 mL cup of coffee provided to him/her by Activities Aide, Staff D.<br><br>During a surveyor interview on 12/9/2024, following the above observation with Staff D, she indicated that she was unaware of Resident ID #30's fluid restriction order. | F 698 | | |

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| F 698 | Continued From page 10<br>During a surveyor interview with the resident on 12/10/2024 at 2:36 PM, s/he indicated that s/he was unaware of the physician's order for a fluid restriction. Additionally, s/he was observed to be drinking from a 480 mL travel mug.<br><br>During a surveyor interview on 12/11/2024 at 9:23 AM with Nursing Assistant, Staff E, she revealed that she was unaware that Resident ID #30 had an order for a fluid restriction.<br><br>During a surveyor interview on 12/11/2024 at 9:48 AM with Unit Manager, Staff F, she acknowledged that Resident ID #30 has a physician's order for a 1000 ml daily fluid restriction. Staff F was unable to provide evidence that the resident's daily fluid intake was being monitored.<br><br>During a surveyor interview on 12/11/2024 at 11:59 AM with the Director of Nursing Services she indicated it was her expectation that the staff would be aware of all residents with orders for a daily fluid restriction, that the resident's daily total fluid intake would be monitored, documented in the MAR.<br><br>Record review failed to reveal evidence that the facility was monitoring Resident ID #30's total daily fluid intake from 10/25/2024 per the physician's order, until after it was brought to the facility's attention by the surveyor, on 12/11/2024. | F 698 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 415064 | A. BUILDING _____ B. WING _____ | 12/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PAWTUCKET FALLS HEALTHCARE CENTER | 70 GILL AVENUE PAWTUCKET, RI 02861 |

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| E 000 | Initial Comments<br><br>An Emergency Preparedness Survey was conducted by the Center for Health Facilities and Regulation on 12/9/2024 through 12/10/2024. The facility was found to be in compliance with 42 CFR §483.73 related to Emergency Preparedness.<br><br>Capacity: 154 Census: 89 | E 000 | | |

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

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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| | 415064 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 12/10/2024 |

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| K 000 | INITIAL COMMENTS<br><br>The annual Federal Life Safety Code survey was conducted by the State Survey Agency. Pawtucket Falls Healthcare Center was surveyed pursuant to the National Fire Protection Association 101 Life Safety Code, 2012 Edition as referenced in 42 CFR 483.90 (a - d) Physical Environment.<br><br>Life Safety Code deficiencies were identified during the survey.<br><br>Capacity: 154 Census: 89 | K 000 | | |
| K 712 SS=F | Fire Drills<br>CFR(s): NFPA 101<br><br>Fire Drills<br>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.<br>19.7.1.4 through 19.7.1.7<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, it has been determined that the facility failed to provide evidence that fire drills were conducted in accordance with the National Fire Protection Association (NFPA) 101 2012 Edition section 19.7.1. This deficient practice has the potential to impact 89 of 89 residents, as well as an indeterminable number of staff and visitors. | K 712 | K 712Fire Drills<br><br>1.Facility has formulated a plan that will ensure the facility maintains a quarterly schedule testing for fire drills which will be conducted at various times.<br><br>2.The Maintenance Director will maintain a schedule and will confirm the service dates/times and will provide a report of completion to the Administrator and the QAPI Committee.<br><br>3.A) Maintenance Director Educated on the regulatory requirements for Fire drills.<br>B) Random monthly audits x 3 will be conducted by Maintenance or designee for compliance and results will be reviewed at quarterly QAPI Meetings until substantial compliance is met.<br><br>4.The Maintenance Director and/or designee is responsible for compliance of this PoC. | 1/10/25 |

CM 12/24/24

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| K 712 | Continued From page 1<br><br>Findings are as follows:<br><br>Review of NFPA 101 2012 edition, Chapter 19, Existing Health Care occupancies, states in part, "...19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions."<br><br>Review of the Centers for Medicare and Medicaid Services (CMS) regulations states in part, "...Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift."<br><br>Record review of the facility's fire drill documentation on 12/10/2024, revealed that the fire drills were not conducted at varied times on all shifts as documented below:<br><br>1) First shift fire drills were conducted at:<br><br>-10:00 AM on 1/12/2024<br>-10:00 AM on 6/15/2024<br>-10:30 AM on 10/30/2024<br><br>2) Second shift fire drills were conducted at:<br><br>- 4:00 PM on 2/28/2024<br>- 3:45 PM on 10/30/2024<br><br>During an interview with the Administrator and the Director of Maintenance on 12/10/2024 at 1:30 PM, they were unable to provide evidence that the required fire drills were being conducted at varied times, on all shifts. | K 712 | | |

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| K 918 SS=F | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>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.<br>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.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, it has | K 918<br>12/24/24 | K 918Essential Electrical System<br><br>1.Facility has formulated a plan that will ensure the facility maintains a quarterly schedule testing for Generator with documented calculation of the load in kilowatts during monthly load test to confirm meeting the minimum 30% of the name plate rating.<br><br>2.The Maintenance Director will maintain a schedule and will confirm the generator documentation with dates/times and will provide a report of completion to the Administrator and the QAPI Committee.<br><br>3.A) Maintenance Director Educated on the regulatory requirements for Generator Testing.<br>B) Random monthly audits x 3 will be conducted by Maintenance or designee for compliance and results will be reviewed at quarterly QAPI Meetings until substantial compliance is met.<br><br>4.The Maintenance Director and/or designee is responsible for compliance of this PoC. | 1/10/25 |

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| K 918 | Continued From page 3<br>been determined that the facility failed to ensure that the Emergency Power Supply System (EPSS) generator was maintained in accordance with National Fire Protection Association (NFPA) 99 Health Care Facilities Code 2012 Edition, NFPA 101 Life Safety Code 2012 Edition, and NFPA 110 Standard for Emergency and Standby Power Systems 2010 Edition. This deficient practice has the potential to impact 89 of 89 residents as well as an indeterminable number of staff and visitors.<br><br>Findings are as follows:<br><br>NFPA 110 2010 edition states in part,<br><br>"8.4 Operational Inspection and Testing.<br>8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly.<br>8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:<br>(1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer<br><br>(2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate Kilowatt rating."<br><br>Record review failed to reveal evidence the facility documented calculations of the load on the generator in Kilowatts during the monthly load test, to confirm that they were meeting the minimum 30% of the name plate rating, for 12 of 12 months reviewed.<br><br>During a surveyor interview with the Maintenance | K 918 | | |

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| K 918 | Continued From page 4<br>Director on 12/10/2024 at approximately 12:15 PM, he was unable to provide evidence that the that the facility was calculating the load on the EPSS generator in Kilowatts to confirm that they were meeting the minimum 30% of the name plate rating, as required. | K 918 | | |
| K 923 SS=F | Gas Equipment - Cylinder and Container Storag<br>CFR(s): NFPA 101<br><br>Gas Equipment - Cylinder and Container Storage<br>Greater than or equal to 3,000 cubic feet<br>Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.<br>>300 but <3,000 cubic feet<br>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 (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.<br>Less than or equal to 300 cubic feet<br>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.<br>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."<br>Storage is planned so cylinders are used in order of which they are received from the supplier. | K 923 | K 923Gas Equipment- Cylinder and Container Storage<br><br>1.Facility has formulated a plan that will ensure the facility maintains a maintenance director/designee will do rounds to check oxygen closet and ensure segregation of full and empty portable cylinders from one another.<br><br>2.The Maintenance Director will maintain an audit tool that will keep track of the oxygen closet, will documentation with dates/times and will provide an audit report of completion to the Administrator and the QAPI Committee.<br><br>3.A) Maintenance Director Educated on the regulatory requirements, [redacted].<br>B)Random monthly audits x 3 will be conducted by Maintenance or designee for compliance and results will be reviewed at quarterly QAPI Meetings until substantial compliance is met.<br><br>4.The Maintenance Director and/or designee is responsible for compliance of this PoC. | 1/10/25 |

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| K 923 | Continued From page 5<br>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.<br>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain oxygen cylinders in accordance with the National Fire Protection Association (NFPA) 99, 2012 Edition. This deficient practice has the potential to impact 89 of 89 residents and an indeterminable number of staff and visitors.<br><br>Findings are as follows:<br><br>Review of NFPA 99, 2012 Edition states in part,<br><br>"11.6.5 Special Precautions - Storage of Cylinders and Containers...<br><br>11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders...<br><br>11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner..."<br><br>Surveyor observation made during the Life Safety Code Tour, in the presence of the Maintenance Director on 12/10/2024, revealed that the oxygen closet on the second floor failed to segregate full and empty portable oxygen cylinders from one another, as required. | K 923 | | |

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| K 923 | Continued From page 6<br><br>During a surveyor interview with the Maintenance Director following the above observation, he acknowledged that the facility failed to segregate full and empty oxygen cylinders from one another, as required. | K 923 | | |