

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 528511	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 5/19/2025
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NAME OF PROVIDER OR SUPPLIER MARQUETTE COUNTY MEDICAL CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 200 W SAGINAW ST ISHPEMING, MI 49849
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(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 May 19, 2025, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey Marquette County Medical Care Facility was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		
E0013 SS= F	Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization	E0013	Element 1: Policy for Natural Gas Outage created on 06/04/2025 Element 2: All residents have the potential to be impacted by this deficiency. Best practice is to have a policy surrounding natural gas outage. Element 3: Physical plant manager and Administrator created policy and staff were educated on 06/05/2025. Element 4: Physical Plant Manager will be responsible for sustained compliance.	6/5/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/05/2025

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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	<p>must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to develop Emergency Preparedness policies and procedures, based on the emergency plan, risk assessment and communication plan. The policies and procedures must be reviewed and updated at least annually. This deficient</p>			

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	<p>practice could affect all occupants in the event of an emergency.</p> <p>Findings Include:</p> <p>On May 19, 2025 at approximately 10:45 AM, record review revealed the facility failed to establish policies and procedures for the loss of natural gas to their building. Policies should be created to identify facility plans to maintain operations when and if natural gas to their building is interrupted. This finding was confirmed by the Maintenance Director at the time of record review.</p>				

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K0000 SS=	<p>INITIAL COMMENTS</p> <p>On May 19, 2025, a Life Safety Recertification Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Marquette County Medical Care Facility 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.</p> <p>The facility is a one story building of type V (111) construction, built in multiple stages. The original 1987 portion of the building is fully suppressed with a dry sprinkler system. The 2002 edition (500 and 600 wings) is fully suppressed with a wet sprinkler system. The 2018 edition (dining/therapy/700 wing) is fully suppressed with a wet and dry system and is separated from the rest of the building by a 2-hour rated fire wall. The building has supervised smoke detection in the corridors, areas open to the corridor and battery-operated single station smoke detectors in resident rooms in the 500 and 600 wings.</p> <p>Building 1 encompasses the 1987 and 2002 portions of the building. Building 2 encompasses the 2018 edition.</p> <p>The facility has 140 certified beds. At the time of the survey the census was 122.</p>	K0000		
K0222 SS= E	Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side	K0222	Element 1: 600 wing exit needed a PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS sign. Signs were placed ont the door on 06/03/2025.	6/3/2025

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	<p>unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.</p>		<p>Element 2: All residents in the solarium/staff/visitors have the potential to be impacted by this deficiency. Element 3: Sign was placed on the door on 06/03/2025 stating PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS Element 4: Physical Plant Manager will be responsible for sustained compliance.</p>	

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	<p>18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure doors in a required means of egress are not equipped with a latch or lock that requires the use of a tool or key from the egress side unless meeting the special locking arrangements for clinical needs in accordance with 19.2.2.2.5.1 and 19.2.2.2.6. This deficient practice could affect all occupants in the solarium in the event of a fire or emergency.</p> <p>Findings Include:</p> <p>On May 19, 2025, at approximately 2:06 PM, observation revealed the door going from the solarium into the 600 wing is a posted exit, with 15-second delayed egress hardware installed. Additionally, the door did not have a "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" sign as required by NFPA 101, 7.2.1.6.1.1 (4). This finding was confirmed by the Maintenance Director at the time of discovery,</p>				

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K0293 SS= E	<p>Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure exit and directional signs are displayed in accordance with 7.10, continuously illuminated and served by the emergency lighting system as required by 19.2.10.1. This deficient practice could affect all of the occupants in 700 wing in the event of an emergency.</p> <p>Findings Include:</p> <p>On May 19, 2025 at approximately 11:39 AM, observation revealed door 8 leads to the exterior of the building, but is not a posted exit. This door could be mistaken as an exit, and therefore shall have signage as required by 7.10.8.3 stating, "NO EXIT". This finding was confirmed by the Maintenance Director at the time of discovery.</p>	K0293	<p>Element 1: 700 wing door did not have NO EXIT required signage. Signs were placed on the door on 06/03/2025. Element 2: All residents on the 700 wing/staff or visitors have the potential to be impacted by this deficiency. This deficient practice could cause someone to use this door as an exit . Element 3: Signage was placed on he door on 06/3/2025 stating NO EXIT Element 4: Physical Plant Manager will be responsible for sustained compliance.</p>	6/3/2025	

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K0324 SS= F	<p>Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with 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</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure cooking facilities are protected in accordance with NFPA 96. This deficient practice could affect all occupants in the event of a fire emergency.</p> <p>Findings Include:</p> <p>On May 19, 2025, at approximately 9:36 AM, record review of the Owners Hood Suppression Inspection form revealed the facility failed to conduct a monthly inspection during December 2024. This finding was confirmed by the Maintenance Director at the time of discovery.</p>	K0324	<p>Element 1: Hood suppression inspection was not completed in December of 2024. Inspections will be completed monthly.</p> <p>Element 2: All staff of the food and nutrition department have the potential to be impacted. If fire spreads all residents and staff have the potential to be impacted.</p> <p>Element 3: Hood suppression inspection will be completed monthly and documented as such.</p> <p>Element 4: Physical Plant Manager will be responsible for sustained compliance. Monthly audits will be performed with results to QAPI.</p>	6/3/2025

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K0345 SS= E	<p>Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure the fire alarm system was tested and maintained in accordance with an approved program complying with NFPA 70 and NFPA 72. This deficient practice could affect all of the occupants in the 500 and 600 wings in the event of a fire.</p> <p>Findings Include:</p> <p>On May 19, 2025, at 9:52 AM, observation and record review determined there are battery operated smoke detectors installed in the resident rooms located on 500 and 600 wing. During physical inspection of the devices it was revealed the majority of devices in the resident rooms exceeded their 10 year life span, and were still in service. The devices had a manufacture date of May 17, 2001. This finding was confirmed by the Maintenance Director at the time of discovery.</p>	K0345	<p>Element 1: Resident room smoke detectors on 500/600 were beyond their 10 year life span. Unrequired room smoke detectors will be removed, as hallway smoke detectors connected to fire system are sufficient under the requirement.</p> <p>Element 2: There are hallway smoke detectors in these units that are connected to the building fire system. Without them all residents/visitors/staff of the 500/600 units would be impacted.</p> <p>Element 3: The battery operated smoke detectors that are in individual resident rooms will be removed by 06/30/2025 as individual room smoke detectors are not required.</p> <p>Element 4: Physical Plant Manager will be responsible for sustained compliance.</p>	6/30/2025	

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K0351 SS= E	<p>Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to provide a sprinkler system installed as required by NFPA 13. This deficient practice could affect all occupants in the 300 wing in the event of a fire emergency.</p> <p>Findings Include:</p> <p>On May 19, 2024, at approximately 1:56 PM, observation revealed a hot water pipe being supported and hanging from a sprinkler pipe in the 300 wing mechanical room. This finding was confirmed by the Maintenance Director at the time of discovery.</p>	K0351	<p>Element 1: Hot water pipe was supported and hanging from sprinkler pipe. Hot water pipe will be removed from sprinkler pipe and supported from ceiling.</p> <p>Element 2: All residents/visitors/staff of the 300 wing have the potential to be impacted by this deficient practice in the event of need for sprinkler use.</p> <p>Element 3: On 06/03/2025 the hanger was removed from the sprinkler pipe and the hot water pipe was secured directly to the ceiling.</p> <p>Element 4: Physical Plant Manager will be responsible for sustained compliance.</p>	6/3/2025
K0363	Corridor - Doors Corridor - Doors Doors	K0363	Element 1: Doors to the courtyard from the	7/16/2025

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SS= E	<p>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 protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:</p>		<p>500 and 600 wings failed to close a positive latch. Physical plant manager contacted multiple vendors and latching hardware will be installed. Element 2: This deficient practice has the potential to impact all occupants of the 500 and 600 wings in the event of a fire. Element 3: Superiorland Electronics will install latching hardware by 07/16/2025. Element 4: Physical Plant Manager will be responsible for sustained compliance. Audits will be done monthly and brought to QAPI.</p>	

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	<p>Based on observation and interview, the facility failed to ensure doors protecting corridor openings are capable of resisting the passage of smoke as required by NFPA 19.3.6.3. This deficient practice could affect all of the occupants on 500 and 600 wings in the event of a fire.</p> <p>Findings Include:</p> <p>On May 19, 2025, between the hours of 1:29 PM and 1:52 PM, observation revealed the vestibule doors to the courtyard from the 500 wing and 600 wing failed to close to a positive latch as required. This finding was confirmed by the Maintenance Director at the time of discovery.</p>			

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K0374 SS= E	<p>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:</p> <p>Based on observation and interview, the facility failed to ensure smoke barrier doors meet the requirements of the LSC. This deficient practice could affect 20 occupants in the event of a fire.</p> <p>Findings Include:</p> <p>On May 19, 2024, at approximately 1:11 PM, observation revealed the main entrance cross corridor smoke barrier doors failed to completely close as required. This finding was confirmed by the Maintenance Director at the time of discovery.</p>	K0374	<p>Element 1: Doors in the entry hallway failed to completely close. Doors and air flow were adjusted for complete closure. Element 2: This deficient practice has the potential to impact the 20 staff near those doors in the event of a fire. Element 3: On 06/03/2025 Automated Comfort Controls were at the facility readjusted the air flow to allow for complete closure of fire doors. Element 4: Physical Plant Manager will be responsible for sustained compliance. Audits will be done weekly x 8 weeks then monthly and brought to QAPI.</p>	6/3/2025

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K0712 SS= F	<p>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:</p> <p>Based on record review and interview, the facility failed to conduct fire drills as required by 19.7.1.4 through 19.7.1.7. This deficient practice could affect all occupants in the event of a fire</p> <p>Findings Include:</p> <p>On May 19, 2025, at approximately 10:02 AM, record review revealed the fire drills conducted during the last 12 months on the third shift (11pm-7am) revealed the facility failed to ensure the alarm signal was transmitted to the fire alarm company within a reasonable timeframe. This finding was confirmed by the Maintenance Director at the time of discovery.</p>	K0712	<p>Element 1: Failure to ensure the alarm signal was transmitted to the fire alarm company within a reasonable time frame. Audible alarm will be used during all drills.</p> <p>Element 2: All occupants have the potential to be impacted by this deficient practice.</p> <p>Element 3: Physical Plant Manager instructed night shift maintenance person responsible for the drills to use audible alarm on 06/03/2025.</p> <p>Element 4: Physical Plant Manager will be responsible for sustained compliance. Audits will be done quarterly and brought to QAPI.</p>	6/3/2025
K0914 SS= E	<p>Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at</p>	K0914	<p>Element 1: Multiple outlets in resident rooms failed inspection and documentation did not indicate repair or replacement. Documentation now includes date and type of corrective action.</p> <p>Element 2: This deficient practice has the potential to impact the 30 residents near those outlets in the event of a fire.</p> <p>Element 3: Physical Plant Manager instructed maintenance personnel to document the date</p>	6/3/2025

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K0918 SS= F	<p>these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing as required by NFPA 99. This deficient practice could affect 30 occupants in the event of a fire</p> <p>Findings Include:</p> <p>On May 19, 2025, at approximately 10:24 AM, record review of the 2024, outlet inspection record revealed multiple outlets in resident rooms throughout the building failed inspection. No corrective action or documentation was provided to indicate the outlets were repaired or replaced. This finding was confirmed by the Maintenance Director at the time of Discovery.</p> <p>Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source</p>	K0918	<p>and type of corrective action on 06/03/2025. Element 4: Physical Plant Manager will be responsible for sustained compliance. Audits will be done monthly and brought to QAPI.</p> <p>Element 1: Facility failed to ensure generator battery was tested for specific gravity. Battery was replaced 06/04/2025 which allows for specific gravity measurement.</p>	6/4/2025

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	<p>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)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure generators or other alternative power source are in accordance with NFPA 110, NFPA 99, NFPA 111 and NFPA 70. This deficient practice could affect all occupants in the event of a power failure.</p>		<p>Element 2: All occupants have the potential to be impacted in the event of power loss. Element 3: Battery was replaced 06/04/2025 which allows for specific gravity measurement. Reading was in compliance on 06/04/2025. Element 4: Physical Plant Manager will be responsible for sustained compliance. Audits will be done monthly and brought to QAPI.</p>		

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	<p>Findings Include:</p> <p>On May 19, 2025, at approximately 10:14 AM, record review revealed the facility failed to conduct specific gravity or conductance testing of the generator batteries during the following months: May 2024, July 2024 through time of survey. This finding was confirmed by the Maintenance Director at the time of discovery.</p>				