

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>724010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>4/14/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>KING NURSING &amp; REHABILITATION COMMUNITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2280 TOWER HILL RD HOUGHTON LAKE, MI 48629</b>
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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 April 14, 2025, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, King Nursing & Rehabilitation Community was found to be not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		
E0039 SS= F	EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this	E0039	E039 #1 Facility failed to conduct exercises to test the Emergency Preparedness Plan at least Annually.  #2 Facility Maintenance Director was educated on putting Emergency Preparedness Drill copies into the Life Safety Book when completed.  #3 Maintenance Director retrieved and made copies of both the Table Top Drill and an actual EmergencyDrill.  #4 Any further Table Top drills and /or conducted Emergency Preparedness Drill exercises will be conducted at least annually, and paperwork will be kept in the Life Safety Manual.  #5 It will be the responsibility of the Maintenance Director to continue to conduct Emergency Plan Exercises at least annually.	5/23/2025

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

TITLE

(X6) DATE

Electronically Signed

05/02/2025

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>section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop</p>			

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	<p>that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p>			

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	<p>(i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. * [For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based</p>			

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	<p>functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-</p>			

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	<p>based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of</p>			

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	<p>all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d) (2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least</p>			

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	<p>annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The facility must participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual,</p>			

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	<p>facility-based. If the facility based experiences an actual natural or man-made emergency that requires activation of the emergency plan, the facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. The facility must conduct an additional exercise that may include, but is not limited to a second full-scale exercise that is community-based or individual, facility-based. A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. The facility must analyze the response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the facility's emergency plan, as needed. This deficient practice could affect 61 out of 61 occupants in the event of a facility wide or community disaster.</p> <p>Findings include;</p> <p>On April 14, 2025, during review of facility emergency preparedness records at approximately 1:25 PM, revealed the facility failed to provide documentation for the required annual full-scale facility-based exercise or full-scale community-based exercise nor any documentation of an actual event that would qualify as a test of the emergency plan, nor was there a tabletop exercise within the last year. No document was provided during survey.</p> <p>These findings were confirmed through interview with the Facility Administrator at the time of record review.</p>			

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K0000 SS=	<p><b>INITIAL COMMENTS</b></p> <p>On April 14, 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, King Nursing &amp; Rehabilitation Community 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 II (111) construction, built in 1969. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors.</p> <p>The facility has 61 certified beds. At the time of the survey the census was 38.</p>	K0000			
K0345 SS= F	<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 record review and interview, the facility</p>	K0345	<p>K345 #1 All current reports were place in the Fire Safety Manual. The documentation for the semiannual visual inspection of the fire alarm system was completed on 3/13/25 and reports were obtained and placed in the Fire Safety Manual. Any items that need to be addressed will be corrected by Summit Fire Protection on 5/22/25</p> <p>#2 A review of all reports was completed to insure accuracy and completeness.</p> <p>#3 Maintenance Director was educated on</p>	5/23/2025	

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K0353 SS= F	<p>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 occupants in the event of a fire emergency.</p> <p>Findings Include:</p> <p>1. On April 14, 2025, during review of facility records at approximately 10:00 AM, revealed the facility failed to provide documentation fire alarm inspection was tested per NFPA 101, 9.6.1.3. Vendor report dated 03/13/2025, revealed 28 devices untested.</p> <p>2. On April 14, 2025, during review of facility records at approximately 10:05 AM, revealed the facility failed to provide documentation the semiannual visual inspection of the fire alarm initiating devices were completed per NFPA 72, 14.3. No activity reports were provided at the time of survey.</p> <p>These findings were confirmed through interview with the Maintenance Assistant at the time of record review.</p> <p>Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water _____</p>	K0353	<p>following up on making sure all Fire Alarm System tests have been completed and complete paperwork is in Life Safety Manual.</p> <p>#4 Any further Fire Alarm System tests will be followed up on to make sure all are completed and all paperwork is received and placed in the Life Safety Manual.</p> <p>#5 It will be the responsibility of the Maintenance Director and the Administrator to ensure sustained compliance.</p> <p>#1 All items identified during the annual sprinkler testing of 12/23/2024 will be corrected by Summit Fire Protection on 5/22/25. A quarterly flow test was completed on 4/29/25 with no concerns. The guages that were identified as requiring replacement will be replaced on 5/22/25 by SUMmit Fire Protection.</p> <p>#2 All resident have the potential of being affected by the deficient practice. All reports</p>	5/23/2025

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NAME OF PROVIDER OR SUPPLIER  <b>KING NURSING &amp; REHABILITATION COMMUNITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>2280 TOWER HILL RD HOUGHTON LAKE, MI 48629</b>	
(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
	<p>system supply source _____ Provide in</p> <p>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:</p> <p>Based on observation, record review and interview, the facility failed to provide sprinkler system maintenance and testing as required by NFPA. This deficient practice could affect approximately all occupants in the event of a fire emergency.</p> <p>Findings Include:</p> <p>1. On April 14, 2025, during review of facility records at approximately 10:28 AM, revealed the facility failed to provide documentation deficiencies found during the annual sprinkler system inspection dated 12/23/2024, were corrected.</p> <p>2. On April 14, 2025, during review of facility records at approximately 10:30 AM, revealed the facility failed to provide documentation required quarterly flow test of the automatic sprinkler system was completed during the 1st quarter of 2025.</p> <p>3. On April 14, 2025, at approximately 11:28 AM, observation revealed three sprinkler gauges located in the basement, one was dated 2/20 and two gauges were undated. Per NFPA 25, 5.3.2, gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. No documentation was provided reference the installation/manufacture dates of the gauges with no dates.</p>		<p>were reviewed and a corrective action repair visit was scheduled for 5/22/25.</p> <p>#3 Maintenance Director was educated to provide all paperwork and proof of Sprinkler System Testing in Life Safety Manual.</p> <p>#4 Any further Sprinkler System Maintenance and Testing paperwork will be kept in Life Safety Manual.</p> <p>#5 It will be the responsibility of the Maintenance Director and Administrator to insure sustained compliance.</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>KING NURSING &amp; REHABILITATION COMMUNITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2280 TOWER HILL RD HOUGHTON LAKE, MI 48629</b>	
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K0521 SS= F	<p>These findings were confirmed through interview with the Maintenance Assistant and Housekeeping/Laundry Manager at the time of record review and observation.</p> <p>HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure heating, ventilation and air conditioning is in compliance with NFPA. This deficient practice could affect all occupants in the event of a fire emergency.</p> <p>Findings Include:</p> <p>On April 14, 2025, during review of facility records at approximately 9:40 AM, revealed the facility failed to provide documentation the 4-year testing of the fire dampers were completed per NFPA 80, 19.4. Vendor report dated 03/14/2025, revealed 15 out of 30 fire dampers were inspected/tested. There was a different vendor report found dated 08/09/2022, which revealed only 8 fire dampers were inspected/tested and all passed.</p> <p>These findings were confirmed through interview with the Maintenance Assistant at the time of record review.</p>	K0521	<p>K521</p> <p>#1 The missing report was obtained and placed in the Life Safety Manual to ensure all 30 items were tested.</p> <p>#2 All residents have the potential to be affected by this deficiency. Any deficiencies identified will be corrected by Summit Fire Protection on 5/22/25.</p> <p>#3 The Maintenance Director was educated on providing all paperwork as proof that the heating, ventilation and air conditioning is in compliance with NFPA and paperwork will be kept in the Life Safety Manual.</p> <p>#4 Any further heating, ventilation and air conditioning shall continue to stay in compliance with NFPA and paperwork will be provided and put in Life Safety Manual.</p> <p>#5 It will be the responsibility of the Maintenance Director and Administrator to insure sustained compliance.</p>	5/23/2025
K0918 SS= F	<p>Electrical Systems - Essential Electric Syste</p> <p>Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source</p>	K0918	<p>K918</p> <p>#1 Based on record review and interview, the facility failed to ensure generators or other alternative power source are in accordance</p>	5/6/2025

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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 electrical failure requiring emergency</p>		<p>with NFPA 110, NFPA 99, NFPA 111 and NFPA 70. This deficient practice could affect all occupants in the event of electrical failure requiring emergency generator power.</p> <p>#2 Facility Maintenance Director was educated that there must be weekly generator inspections and that there needs to be a monthly load test as well.</p> <p>#3 The Maintenance Director immediately corrected his inspections to weekly and will continue his monthly load test as well. Proof will be kept in Life Safety Manual.</p> <p>#4 All further weekly and monthly logs will be kept in Life Safety Manual.</p> <p>#5 It will be the responsibility of the Maintenance Director to insure sustained compliance.</p>	

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	<p>generator power.</p> <p>Findings Include:</p> <p>On April 14, 2025, during review of facility records at approximately 10:47 AM, revealed the facility failed to provide documentation weekly inspections of the generator were completed for the last 12 months per NFPA 110, 8.4.1. The only weekly inspections provided at the time of survey were one weekly inspection per month for the last 12 months.</p> <p>These findings were confirmed through interview with the Maintenance Assistant at the time of record review.</p>			