STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195174	A. BUILDING _____ B. WING _____	01/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON ORLEANS HEALTHCARE OF NEW ORLEANS	1420 GENERAL TAYLOR NEW ORLEANS, LA 70115

(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
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted on 01/08/2021. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended Practices to prepare for COVID-19. Total Residents: 164	F 000		

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

Electronically Signed | 01/11/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195174	A. BUILDING _____ B. WING _____	C 01/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON ORLEANS HEALTHCARE OF NEW ORLEANS	**1420 GENERAL TAYLOR NEW ORLEANS, LA 70115**

(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
F 000	INITIAL COMMENTS Complaint #LA00056835. No deficiencies cited as a result of this complaint. A COVID-19 Focused Infection Control Survey was conducted on 01/21/2021. The facility was found to be in compliance with 42 CRF 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total Residents : 139	F 000		

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

Electronically Signed | 01/26/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195174	A. BUILDING _____ B. WING _____	02/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON ORLEANS HEALTHCARE OF NEW ORLEANS	1420 GENERAL TAYLOR NEW ORLEANS, LA 70115

(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
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted on 02/03/2021. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total residents: 154	F 000		

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

Electronically Signed | 02/09/2021

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195174	A. BUILDING _____ B. WING _____	C 02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON ORLEANS HEALTHCARE OF NEW ORLEANS	**1420 GENERAL TAYLOR NEW ORLEANS, LA 70115**

(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
F 000	INITIAL COMMENTS Complaint #LA00056961. No deficiencies cited as a result of this complaint.	F 000		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195174	A. BUILDING _____ B. WING _____	C 05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON ORLEANS HEALTHCARE OF NEW ORLEANS	**1420 GENERAL TAYLOR NEW ORLEANS, LA 70115**

(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
F 000	INITIAL COMMENTS "Complaint Survey #LA00057455 and #LA00057866" No deficiencies cited as a result of these complaints. Census: 162	F 000		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195174	A. BUILDING _____ B. WING _____	06/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON ORLEANS HEALTHCARE OF NEW ORLEANS	1420 GENERAL TAYLOR NEW ORLEANS, LA 70115

(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
F 884 SS=F	Reporting - National Health Safety Network CFR(s): 483.80(g)(1)(i)-(ix)(2) §483.80(g) COVID-19 reporting. The facility must-- §483.80(g)(1) Electronically report information about COVID-19 in a standardized format specified by the Secretary. This report must include but is not limited to- (i) Suspected and confirmed COVID-19 infections among residents and staff, including residents previously treated for COVID-19; (ii) Total deaths and COVID-19 deaths among residents and staff; (iii) Personal protective equipment and hand hygiene supplies in the facility; (iv) Ventilator capacity and supplies in the facility; (v) Resident beds and census; (vi) Access to COVID-19 testing while the resident is in the facility; (vii) Staffing shortages; (viii) The COVID-19 vaccine status of residents and staff, including total numbers of residents and staff, numbers of residents and staff vaccinated, numbers of each dose of COVID-19 vaccine received, and COVID-19 vaccination adverse events; and (ix) Therapeutics administered to residents for treatment of COVID-19. §483.80(g)(2) Provide the information specified in paragraph (g)(1) of this section at a frequency specified by the Secretary, but no less than weekly to the Centers for Disease Control and Prevention ' s National Healthcare Safety Network. This information will be posted publicly by CMS to support protecting the health and safety of residents, personnel, and the general	F 884		6/28/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/28/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195174	A. BUILDING _____ B. WING _____	06/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON ORLEANS HEALTHCARE OF NEW ORLEANS	1420 GENERAL TAYLOR NEW ORLEANS, LA 70115

(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
F 884	Continued From page 1 public. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to report complete information about COVID-19 to the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) during a seven-day period that reporting was required by regulation. The CDC submitted data from the NHSN to the Centers for Medicare and Medicaid Services (CMS). Based on review of that data, CMS determined that between 06/21/2021 and 06/27/2021, the facility did not report complete information to NHSN about COVID-19 in the standardized format and frequency as specified by CMS and the CDC. This failure to report has the potential to cause more than minimal harm to all residents residing in the facility.	F 884		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195174	A. BUILDING _____ B. WING _____	C 07/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON ORLEANS HEALTHCARE OF NEW ORLEANS	**1420 GENERAL TAYLOR NEW ORLEANS, LA 70115**

(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
F 000	INITIAL COMMENTS Complaint Survey #LA00058322. No deficiencies cited as a result of this complaint.	F 000		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195174	A. BUILDING **01** B. WING _____	**08/17/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON ORLEANS HEALTHCARE OF NEW ORLEANS	**1420 GENERAL TAYLOR** **NEW ORLEANS, LA 70115**

(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
K 000	INITIAL COMMENTS Maison Orleans Healthcare of New Orleans is not in compliance with the requirements of Title 42 Code of Federal Regulations, Part 483.70(a) (Life Safety Code). The findings that follow in this CMS 2567 demonstrate the non-compliance. The facility is sprinklered, licensed for two hundred beds and a census of one hundred eighty-two residents at time of survey.	K 000		
K 345 SS=C	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 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: Based on visual observation the facility failed to assure that the fire alarm system was inspected and tested in accordance with the approved maintenance and testing program in NFPA 72. The fire alarm system gives a sense of security to offer an advance warning in fire and/or smoke emergency. This deficient practice could potentially affect one hundred eighty-two of one hundred eighty-two residents. Findings: During the facility tour on August 17, 2021 between the hours of 10:00 a.m. to 2:30 p.m. the	K 345		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195174	A. BUILDING **01** B. WING _____	**08/17/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON ORLEANS HEALTHCARE OF NEW ORLEANS	**1420 GENERAL TAYLOR** **NEW ORLEANS, LA 70115**

(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
K 345	Continued From page 1 fire alarm system was lacking a annual certification from a licensed fire alarm agent. The last annual certification conducted by a licensed fire alarm agent expired on July 22, 2021. NFPA 72: 10.3.2 System components shall be installed, tested, and maintained in accordance with the manufacturer's published instructions and this Code. NFPA 72:10.4.1.2 State or local licensure regulations shall be followed to determine qualified personnel. Depending on state or local licensure regulations, qualified personnel shall include, but not be limited to, one or more of the following: (1) Personnel who are registered, licensed, or certified by a state or local authority. LRS 40:1646 (A)(B)(C) The fire marshal is authorized to cause the inspection and testing of all life safety systems and equipment in the state, whether in public or private buildings, during installation or immediately after installation to determine compliance with applicable standards. The owner of any building containing a life safety system and equipment shall cause at a minimum an annual inspection to be made of the life safety system and equipment in that building to assure compliance with applicable safety standards and to determine whether structural changes in the building or in the contents of the building mandate alteration of a system. Life safety systems and equipment includes but is not limited to fire sprinkler, fire alarm, fire suppression, special locking systems and equipment, and portable fire extinguishers. The interview with the administrator revealed the facility was aware that the required inspections	K 345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195174	A. BUILDING **01** B. WING _____	**08/17/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON ORLEANS HEALTHCARE OF NEW ORLEANS	**1420 GENERAL TAYLOR** **NEW ORLEANS, LA 70115**

(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
K 345	Continued From page 2 had not been conducted on the fire alarm system. The New Orleans area recently had a COVID-19 surge resulting in the facility not allowing visitors within the premises until the COVID-19 surge subsides. A one-time waiver is approved for this K-tag due to the COVID -19 emergency pandemic. This one time waiver is effective until Louisiana Department of Health and Hospitals licensure expiration of September 30, 2022.	K 345		
K 916 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on visual observation the facility is lacking a generator remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard wired to indicate alarm conditions of the emergency power source. A centralized compute system (e. g., building information system) is not to be substituted for the alarm annunciator. This deficient practice could potentially affect one hundred eighty-two of	K 916		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195174	A. BUILDING **01** B. WING _____	**08/17/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON ORLEANS HEALTHCARE OF NEW ORLEANS	**1420 GENERAL TAYLOR** **NEW ORLEANS, LA 70115**

(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
K 916	Continued From page 3 one hundred eighty-two residents. Findings: During the facility tour on August 17, 2021 between the hours of 10:00 a.m. to 2:30 p.m. the facility lacked a hard wired generator annunciator located at a constantly attended location. NFPA 110:5.6.5.2 (4) A individual alarm indicator to annunciate any of the conditions listed in Table 5.6.5.2. The interview with administrator revealed the facility was unaware a hard wired generator annunciator located in a constantly attended location was required by NFPA 110.	K 916		
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195174	A. BUILDING **01** B. WING _____	**08/17/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON ORLEANS HEALTHCARE OF NEW ORLEANS	**1420 GENERAL TAYLOR** **NEW ORLEANS, LA 70115**

(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
K 918	Continued From page 4 competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on visual observation the facility failed to assure that the emergency generator was maintained and tested in accordance with NFPA 110. In cases of a power outage the emergency generator powers essential life safety equipment for the facility. This deficient practice could potentially affect one hundred eighty-two of one hundred eighty-two residents. Findings: During the facility tour on August 17, 2021 between the hours of 10:00 a.m. to 2:30 p.m. the indoor generator was not provided with a remote manual stop and remote manual signage located outside the room housing prime mover. NFPA 110:5.6.5.6 All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195174	A. BUILDING **01** B. WING _____	**08/17/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON ORLEANS HEALTHCARE OF NEW ORLEANS	**1420 GENERAL TAYLOR** **NEW ORLEANS, LA 70115**

(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
K 918	Continued From page 5 so installed, or elsewhere on the premises where the prime mover is located outside the building. NFPA 101:A.5.6.5.6 For systems located outdoors, the manual shutdown should be located external to the weatherproof enclosure and should be appropriately identified. NFPA 110:5.6.5.6.1 The remote manual stop station shall be labeled. The interview with the administrator revealed the facility was not aware that a remote manual stop was required to be located outside the room housing the prime mover.	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195174	A. BUILDING _____ B. WING _____	C 08/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON ORLEANS HEALTHCARE OF NEW ORLEANS	**1420 GENERAL TAYLOR NEW ORLEANS, LA 70115**

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F 000	INITIAL COMMENTS Recertification Survey and Re-Licensing Survey Maison Orleans Healthcare of New Orleans, LLC is in compliance with the requirements of 42CFR, Part 483, Subpart B, Requirements for Long Term Care Facilities. Complaint Survey #LA00058400 and #LA00058789. No deficiencies cited as a result of these complaints.	F 000		

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

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