STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING -- B. WING	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date(s): 11/01/22 & 11/02/22 Facility Number: 000032 Provider Number: 155077 AIM Number: 100273330 At this Emergency Preparedness survey, Envive of Indianapolis was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 184 certified beds. At the time of the survey, the census was 94. Quality Review completed on 11/09/22 The requirement at 42 CFR Subpart 483.73 is NOT MET as evidenced by:	E 0000	**PLAN OF CORRECTION FOR ENVIVE OF INDIANAPOLIS F000 INITIAL COMMENTS Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Recertification and State Licensure completed on November 2, 2022.Please accept this Plan of Correction as the provider's credible allegation of compliance as of November 24, 2022. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.**	
E 0031 SS=F Bldg. --	403.748(c)(2), 416.54(c)(2), 418.113(c)(2), 441.184(c)(2), 482.15(c)(2), 483.475(c)(2), 483.73(c)(2), 484.102(c)(2), 485.625(c)(2), 485.68(c)(2), 485.727(c)(2), 485.920(c)(2), 486.360(c)(2), 491.12(c)(2), 494.62(c)(2)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
KAVITA BERI	HFA	11/22/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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
	155077	A. BUILDING -- B. WING	11/02/2022

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Emergency Officials Contact Information
§403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2).

[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:

(2) Contact information for the following:
(i) Federal, State, tribal, regional, and local emergency preparedness staff.
(ii) Other sources of assistance.

*[For LTC Facilities at §483.73(c):] (2) Contact information for the following:
(i) Federal, State, tribal, regional, and local emergency preparedness staff.
(ii) The State Licensing and Certification Agency.
(iii) The Office of the State Long-Term Care Ombudsman.
(iv) Other sources of assistance.

*[For ICF/IIDs at §483.475(c):] (2) Contact information for the following:
(i) Federal, State, tribal, regional, and local emergency preparedness staff.
(ii) Other sources of assistance.
(iii) The State Licensing and Certification Agency.
(iv) The State Protection and Advocacy Agency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan included all applicable sources of assistance. This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Operations Plan" documentation dated 09/28/22 with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during record review from 9:20 a.m. to 1:45 p.m. on 11/01/22, the emergency preparedness plan did not include contacting the Indiana Department of Health (IDOH) by telephone at 317-460-7287 for emergency incidents that require a full or partial evacuation. The emergency preparedness plan also did not include the contact for IDOH using the Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. The "Emergency Contacts" section of the 09/28/22 plan stated to contact the "Licensing Agency for State/Phone #" at 317/232-2960 which is the "IPLA". Based on interview at the time of record review, the Executive Director stated "IPLA" is the Indiana Professional Licensing Agency. This finding was reviewed with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during the exit conference.	E 0031	POC- Life Safety Tag E0031 SS-F **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents have been affected by the deficient practice, but the emergency preparedness plan now includes contacting the Indiana Department of Health (IDOH) by telephone at 317-460-7287 for emergency incidents that require a full or partial evacuation. The emergency preparedness plan also includes the contact for IDOH using the Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No residents have been affected by the deficient practice, but the emergency preparedness plan has	11/24/2022

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			now been updated in all the binders located at several different locations in the building. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The Emergency Preparedness book will be Audited every month once a month by the Maintenance Director/designee. Maintenance director /Designee will bring the audit sheets back in the morning meeting next day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Maintenance Director/designee will be Auditing the EPP every month once a month. Maintenance director /Designee	

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			will bring the audit sheets back in the morning meeting next day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated Date of compliance November 24th,2022	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health			

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	Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or			

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	go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on record review, observation and interview; the facility failed to implement the emergency power system inspection, testing and	E 0041	POC- Life Safety Tag E0041	11/24/2022

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	maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff and visitors. a. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for the facility's diesel-powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director from 9:20 a.m. to 1:45 p.m. on 11/01/22, documentation of an annual fuel quality test for the diesel fired emergency generator was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility has one diesel fired emergency generator and agreed documentation of an annual fuel quality test for the diesel fired emergency generator was not available for review. This finding was reviewed with the Executive Director, the Director of Maintenance and the		F Level **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents have been affected by the deficient practice, but the facility has performed annual fuel quality test for the facility's diesel-powered generator. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No residents have been affected by the deficient practice, but the facility has performed an audit on annual fuel quality test for the facility's diesel-powered generator. The annual fuel quality test for the facility's diesel-powered generator is updated now. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Annual fuel quality test on the diesel-powered generator will be	

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	Corporate Maintenance Director during the exit conference. b. Based on record review, observation and interview; the facility failed to document 36 month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director from 9:20 a.m. to 1:45 p.m. on 11/01/22, thirty-six month period emergency generator testing documentation for four continuous hours for the diesel fired emergency generator was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility has one diesel fired emergency generator and agreed		Audited every month once a month by the Maintenance Director/designee. Maintenance director /Designee will bring the audit sheets back in the morning meeting next day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Annual fuel quality test on the diesel-powered generator will be Audited every month once a month by the Maintenance Director/designee. Maintenance director /Designee will bring the audit sheets back in the morning meeting next day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make	

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	documentation of supplemental load testing for four hours within the most recent three year period was not available for review. Based on observations with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during a tour of the facility from 9:15 a.m. to 11:50 a.m. on 11/02/22, the facility has one diesel fired emergency generator located outside the building in its own walk-in weatherproof shell. Manufacturer's nameplate rating for the generator stated it was rated at 600 kW. This finding was reviewed with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during the exit conference.		recommendations to revise the plan of correction as indicated Date of compliance November 24th , 2022	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date(s): 11/01/22 & 11/02/22 Facility Number: 000032 Provider Number: 155077 AIM Number: 100273330 At this Life Safety Code survey, Envive of Indianapolis was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2	K 0000	**PLAN OF CORRECTION FOR ENVIVE OF INDIANAPOLIS F000 INITIAL COMMENTS Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Recertification and State**	

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	This one story facility was determined to be of Type III (211) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and in rooms 11 through 19 in the C Wing. The facility has battery operated smoke detectors in all other resident sleeping rooms. The facility has a capacity of 184 and had a census of 94 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has four detached buildings providing storage services and one detached building housing an emergency generator which were each not sprinklered. Quality Review completed on 11/09/22		**Licensure completed on November 2, 2022.Please accept this Plan of Correction as the provider's credible allegation of compliance as of November 24, 2022. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.**	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to maintain the means of egress free from obstructions in 1 of 8 means of egress. This deficient practice could affect 20 residents, staff and visitors if needing to exit the facility by the east exit door of the main dining room. Findings include: Based on observations with the Executive	K 0211	POC- Life Safety Tag K211 E Level **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	11/24/2022

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	Director, the Director of Maintenance and the Corporate Maintenance Director during a tour of the facility from 9:15 a.m. to 11:50 a.m. on 11/02/22, the exit door to the outside of the facility on the east side of the main dining room was marked as a facility exit with an exit sign. The door also had a keypad at the exit door to release the door to open but the code to release the door to open was not posted at the exit door. The door was not marked as a delayed egress door with the necessary delayed egress signage. Based on interview at the time of the observations, the Director of Maintenance stated the keypad was not operable and a new keypad was on order. The Director of Maintenance stated the door may be a delayed egress door but agreed the door was not posted with the necessary delayed egress signage. This finding was reviewed with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during the exit conference. 3.1-19(b)		**practice?** No residents have been affected by the deficient practice, but the facility has no obstructions in the means of egress now./p> **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No residents have been affected by the deficient practice, all the hallways are audited and different times to ensure that there is no obstructions in the means of egress./p> **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Maintenance director /Designee will complete random audits daily Monday through Sunday four times a week on random shifts including weekends for four weeks, then three times a week for two weeks, then two times a week for the two weeks, once a week for one weeks to ensure that mean of egress are obstruction free. Maintenance director /Designee will review the audits with the IDT during morning	

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			meeting Monday through Friday. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Maintenance director /Designee will complete random audits daily Monday through Sunday four times a week on random shifts including weekends for four weeks, then three times a week for two weeks, then two times a week for the two weeks, once a week for one weeks to ensure that mean of egress are obstruction free. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make	

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			recommendations to revise the plan of correction as indicated/p> Date of compliance November 24th , 2022	
K 0222 SS=E Bldg. 01	NFPA 101 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 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			

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	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. 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			
	1. Based on observation and interview, the facility failed to ensure the means of egress through 2 of 8 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC Section 19.2.2.2.4. Door-locking arrangements	K 0222	POC- Life Safety Tag K222 E Level **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	11/24/2022

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	shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 40 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during a tour of the facility from 9:15 a.m. to 11:50 a.m. on 11/02/22, the exit door to the outside of the facility in the vestibule for the A Wing and in the vestibule for the B Wing were each marked as a facility exit with an exit sign and could be opened by entering a code into a keypad at the door. However, the code was not posted at each exit door. Based on interview at the time of the observations, the Executive Director and the Director of Maintenance stated residents who have a clinical diagnosis to be in a secure wing are in the C Wing and D Wing, not all residents in the A Wing and B Wing have a clinical diagnosis to be in a secure wing and agreed the keypad code to release the exit door to open in the vestibule for the A Wing and the B Wing was not posted at the keypad. This finding was reviewed with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 1 delayed egress locks were readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be		No residents have been affected by the deficient practice, but the facility doors have the code posted now at each exit door in all wings. Delayed egress signs are now posted./p> **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No residents have been affected by the deficient practice, all the hallway door and exits are audited at different times to ensure that there is code posted at each exit and delayed egress signs are now posted./p> **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Maintenance director /Designee will complete random audits daily Monday through Sunday four times a week on random shifts including weekends for four weeks, then three times a week for two weeks, then two times a week for the two weeks, once a week for one weeks to ensure that the facility doors have the code posted now at each exit door in all	

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	installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6. (b) The doors unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect 20 residents, staff and visitors if needing to exit the facility by the east exit door of the main dining room.		wings. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated./p> **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Maintenance director /Designee will complete random audits daily Monday through Sunday four times a week on random shifts including weekends for four weeks, then three times a week for two weeks, then two times a week for the two weeks, once a week for one weeks to ensure that the facility doors have the code posted now at each exit door in all wings. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance	

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	Findings include: Based on observations with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during a tour of the facility from 9:15 a.m. to 11:50 a.m. on 11/02/22, the exit door to the outside of the facility on the east side of the main dining room was marked as a facility exit with an exit sign. The door also had a keypad at the exit door to release the door to open but the code to release the door to open was not posted at the exit door. The door was not marked as a delayed egress door with the necessary delayed egress signage. Based on interview at the time of the observations, the Director of Maintenance stated the keypad was not operable and a new keypad was on order. The Director of Maintenance stated the door may be a delayed egress door but agreed the door was not posted with the necessary delayed egress signage. The Corporate Maintenance Director tested the door to see if it was delayed egress. The door did open after pushing for less than five seconds but the door did not go into alarm when pushed and the delay was well less than fifteen seconds before the door opened. This finding was reviewed with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during the exit conference. 3.1-19(b)		meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated Date of compliance November 24th , 2022	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in			

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	accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review, observation and interview; the facility failed to document monthly and annual testing for all battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Exit Lights/Parking Lot Lights" documentation with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during record review from 9:20 a.m. to 1:45 p.m. on 11/01/22, monthly and annual battery operated light testing documentation for the most recent twelve month period did not include the battery operated light inside the walk-in weather proof shell for the emergency generator location.	K 0291	POC- Life Safety Tag K291 E Level **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents have been affected by the deficient practice, but the facility had now started to document and check the test Emergency operated light inside the walk-in weatherproof shell for emergency generator location monthly and annually. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No residents have been affected by the deficient practice, there is only one emergency operated light on the generator which is audited, checked and documented. **What measures will be put into place and what systemic changes will be made to**	11/24/2022

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	Based on interview at the time of record review, the Director of Maintenance stated he mainly tests exit signage lighting but agreed monthly and annual functional testing documentation for the battery operated light inside the walk-in weather proof shell for the emergency generator location for the most recent twelve month period was not available for review. Based on observations with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during a tour of the facility from 9:15 a.m. to 11:50 a.m. on 11/02/22, only one battery operated lighting system was noted in the facility inside the walk-in weather proof shell location for the emergency generator which functioned when its respective test button was pushed. This finding was reviewed with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during the exit conference. 3.1-19(b)		**ensure that the deficient practice does not recur.** Maintenance director /Designee will complete random audits daily Monday through Sunday four times a week on random shifts including weekends for four weeks, then three times a week for two weeks, then two times a week for the two weeks, once a week for one weeks to ensure that emergency exit lights on the generator are checked and documented. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Maintenance director /Designee will complete random audits daily Monday through Sunday four times a week on random shifts including weekends for four weeks, then three times a week for two weeks, then two times a	

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			week for the two weeks, once a week for one weeks to ensure that emergency exit lights on the generator are checked and documented. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated Date of compliance November 24th , 2022	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 1. Based on observation and interview, the facility failed to replace battery operated smoke alarms installed in 47 of 63 resident sleeping rooms in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service	K 0300	POC- Life Safety Tag K300 SS-E **What corrective action(s) will be accomplished for those residents found to have been**	11/24/2022

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	longer than 10 years from the date of manufacture. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during a tour of the facility from 9:15 a.m. to 11:50 a.m. on 11/02/22, manufacturer's documentation affixed to the Kidde Model i9010 battery operated smoke alarm installed on the ceiling in resident sleeping Room B11 and D4 stated the unit was manufactured 03/12/12 and to "replace the unit within 10 years of installation date". The installation date was not recorded on either battery operated smoke alarm. Based on interview at the time of the observations, the Director of Maintenance stated each resident sleeping room which has a battery operated smoke alarm has the same type of battery operated smoke alarm installed in the room and agreed resident sleeping room battery operated smoke alarms installed in the facility were more than ten years old. This finding was reviewed with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to ensure documentation for the preventative maintenance of all battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained.		**affected by the deficient practice?** No residents have been affected by the deficient practice, but resident room battery operated smoke detectors documentation is current at this time. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No residents have been affected by the deficient practice, building wide audit is completed to ensure battery operated smoke detectors preventive maintenance documentation is current and documented. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Maintenance director /Designee will complete random audits daily Monday through Sunday four times a week on random shifts including weekends for four weeks, then three times a week for two weeks, then two times a week for the two weeks, once a week for one weeks to ensure battery operated smoke detectors documentation is current. Maintenance director /Designee will bring the audit sheets back in	

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	NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, 29.10 Maintenance and Tests states fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director from 9:20 a.m. to 1:45 p.m. on 11/01/22, resident room battery operated smoke detector preventive maintenance documentation for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Director of Maintenance stated he regularly tests battery operated smoke detectors but does not document the testing and agreed resident room battery operated smoke detector testing and cleaning documentation for the most recent twelve month period was not available for review. Based on observations with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during a tour of the facility from 9:15 a.m. to 11:50 a.m. on 11/02/22, manufacturer's documentation affixed to the Kidde Model i9010 battery operated smoke alarm installed on the ceiling in resident sleeping Room B11 and D4 stated to test the unit weekly and to clean the unit annually. Based on interview at the time of the observations, the Director of Maintenance stated each resident sleeping room which has a battery operated smoke alarm has the		morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Maintenance director /Designee will complete random audits daily Monday through Sunday four times a week on random shifts including weekends for four weeks, then three times a week for two weeks, then two times a week for the two weeks, once a week for one weeks to ensure battery operated smoke detectors documentation is current at all times. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA	

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	same type of battery operated smoke alarm installed in the room. This finding was reviewed with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during the exit conference. 3.1-19(b)		committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated Date of compliance November 24th , 2022	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms			

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	(exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of over 13 hazardous areas such as combustible storage rooms over 50 square feet in size were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Central Supply room. Findings include: Based on observations with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during a tour of the facility from 9:15 a.m. to 11:50 a.m. on 11/02/22, the Central Supply room is a storage room for combustible boxes and supplies which was greater than 50 square feet in size. The corridor door to the room was not self closing or automatic closing. Based on interview at the time of the observations, the Director of Maintenance agreed the corridor door to the aforementioned hazardous area was not self closing or automatic closing. This finding was reviewed with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during the exit conference. 3.1-19(b)	K 0321	POC- Life Safety Tag K321 SS-E **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents have been affected by the deficient practice, but Corridor door to the room now has self-enclosure. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No residents have been affected by the deficient practice, building wide audit is completed to ensure all the rooms have self-enclosure where needed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Maintenance director /Designee will complete random audits daily Monday through Sunday four	11/24/2022

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			times a week on random shifts including weekends for four weeks, then three times a week for two weeks, then two times a week for the two weeks, once a week for one weeks to ensure self-enclosures are present on all the needed doors. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Maintenance director /Designee will complete random audits daily Monday through Sunday four times a week on random shifts including weekends for four weeks, then three times a week for two weeks, then two times a week for the two weeks, once a week for one weeks to ensure self-enclosures are present on all the needed doors. Maintenance director /Designee will bring the audit sheets back in morning	

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			meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated Date of compliance November 24th , 2022	
K 0324 SS=D Bldg. 01	NFPA 101 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 Based on record review and interview, the facility failed to ensure repair documentation was	K 0324	POC- Life Safety	11/24/2022

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available for review to ensure 1 of 1 kitchen range hood exhaust systems was maintained in proper working order. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition, Section 4.1.3 states the following equipment shall be kept in working condition:
(1) Cooking equipment
(2) Hoods
(3) Ducts (if applicable)
(4) Fans
(5) Fire-extinguishing equipment
(6) Special effluent or energy control equipment
Section 4.1.3.1 states maintenance and repairs shall be performed on all components at intervals necessary to maintain good working condition. This deficient practice could affect over two kitchen staff.

Findings include:

Based on review of the kitchen range hood fire suppression system inspection contractor's "Fire Systems Report" documentation dated 07/18/22 with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during record review from 9:20 a.m. to 1:45 p.m. on 11/01/22, the kitchen range hood fire suppression system has deficiencies as a result of inspection. The "Comments, Discrepancies of Deficiencies" section of the 07/18/22 inspection reports stated "Micro-switch at A* control box not connected. Rewire connection to allow elec shutoff & alarm activation". Based on interview at the time of record review, the Director of Maintenance stated he was not aware if any repairs had been made on or after 07/18/22 and agreed documentation of any corrections performed on or after 07/18/22 was not available for review at the time of the survey.

Tag K324
SS-E
What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

No residents have been affected by the deficient practice, but kitchen range hood exhaust systems repair documents are maintained in proper working order.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.

No residents have been affected by the deficient practice, Audit for kitchen hood exhaust system had been completed./p>

What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.
Maintenance director /Designee will complete random audits daily Monday through Sunday one times a week on random shifts including weekends for four weeks, then one times a week for two weeks, then one times a week for the one week to ensure but kitchen range hood exhaust

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	This finding was reviewed with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during the exit conference. 3.1-19(b)		systems repair documents are maintained in proper working order. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated./p> **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Maintenance director /Designee will complete random audits daily Monday through Sunday one times a week on random shifts including weekends for four weeks, then one times a week for two weeks, then one times a week for the one week to ensure kitchen range hood exhaust systems repair documents are maintained in proper working order. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince	

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			is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated Date of compliance November 24th , 2022	
K 0353 SS=F Bldg. 01	NFPA 101 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 system supply source _____________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review, observation and interview; the facility failed to complete a full hydrostatic flush for 2 of 2 automatic sprinkler piping systems which failed flow testing and trip testing. NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 14.3.1(3) states an obstruction investigation shall be conducted for system piping whenever foreign materials are in dry pipe valves or in check valves.	K 0353	POC- Life Safety Tag K353 SS-F **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	11/24/2022

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	Section 14.3.3, states if an obstruction investigation indicates the presence of sufficient material to obstruct pipe or sprinklers, a complete flushing program shall be conducted by qualified personnel. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the sprinkler system inspection contractor's "Sprinkler Inspection Certificate" documentation dated 07/11/22 with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during record review from 9:20 a.m. to 1:45 p.m. on 11/01/22, the facility's two dry sprinkler systems failed flow testing and trip testing. Review of the sprinkler system inspection contractor's "Service Proposal" documentation dated 08/11/22 indicated a quote to "remove and flush each inspector's test until clean water is observed". Based on interview at the time of record review, the Director of Maintenance and the Corporate Maintenance Director stated the quote had been approved and the sprinkler system contractor was actively prepping the system for the flush at the time of the survey but had not yet started or completed the flush of the two sprinkler systems. Based on observations with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during a tour of the facility from 9:15 a.m. to 11:50 a.m. on 11/02/22, the sprinkler system contractor was actively prepping the system for the flush by installing additional sprinkler low point drains in advance of flushing the two dry sprinkler systems for the facility. This finding was reviewed with the Executive Director, the Director of Maintenance and the		**practice?** No residents have been affected by the deficient practice, but repair for hydrostatic flush for 2 of 2 automatic sprinkler piping system is in process which failed flow testing and trip testing. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No residents have been affected by the deficient practice, Audit for the facility wide hydrostatic flush had been completed and repair for hydrostatic flush for 2 of 2 automatic sprinkler piping system is in process which failed flow testing and trip testing. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Maintenance director /Designee will complete random audits daily Monday through Sunday one times a week on random shifts including weekends for four weeks, then one times a week for two weeks, then one times a week for the one week to ensure hydrostatic flush for automatic sprinkler piping system is in process which failed flow testing and trip testing. Maintenance	

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	Corporate Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the sprinkler system inspection contractor's "Sprinkler Inspection Certificate" documentation dated 07/11/22 with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during record review from 9:20 a.m. to 1:45 p.m. on 11/01/22, deficiencies were noted for the facility's sprinkler system during the inspection for the facility. The "Notes and Recommendations" section of the 07/11/22 sprinkler system inspection report stated		director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Maintenance director /Designee will complete random audits daily Monday through Sunday one times a week on random shifts including weekends for four weeks, then one times a week for two weeks, then one times a week for the one week to ensure hydrostatic flush for automatic sprinkler piping system is in process which failed flow testing and trip testing. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends	

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	"Accelerator failed to activate" for the "west side A & B Wings" sprinkler system and "Accelerator was out of service upon arrival" for the "east side C & D Wings". Both sprinkler systems had the following statements "systems have 1 PS10 waterflow switch for 2 dry systems. Each system must have a waterflow switch. Systems have 1 air maintenance device for 2 dry systems, each dry system must have an air maintenance device. System has excessive air pressure". Based on interview at the time of record review, the Director of Maintenance and the Corporate Maintenance Director provided an approved "Service Proposal" documentation dated 08/11/22 from the sprinkler system inspection contractor but stated repairs to each system on or after 08/11/22 have not yet been performed because the facility was actively trying to perform sprinkler flushing first. This finding was reviewed with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during the exit conference. 3.1-19(b) 3. Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made		or patterns and make recommendations to revise the plan of correction as indicated Date of compliance November 24th , 2022	

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	available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on record review with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during record review from 9:20 a.m. to 1:45 p.m. on 11/01/22, monthly sprinkler system valve inspection documentation for August, September and October 2022 was not available for review. Based on interview at the time of record review, the Director of Maintenance said he documents sprinkler system gauge inspections but agreed monthly sprinkler system valve inspection documentation for August, September and October 2022 was not available for review. Based on observations with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during a tour of the facility from 9:15 a.m. to 11:50 a.m. on 11/02/22, the facility has supervised dry sprinkler systems. This finding was reviewed with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during the exit conference. 3.1-19(b)			
K 0355 SS=F Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10			

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	1. Based on observation and interview, the facility failed to ensure 3 of 18 portable fire extinguishers had documented annual maintenance in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.3.1.1.1 states fire extinguishers shall be subject to maintenance at intervals of not more than one year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during a tour of the facility from 9:15 a.m. to 11:50 a.m. on 11/02/22, the ABC type portable fire extinguishers located in the Medical Records office in the A Wing short hall, the Central Supply room and the Beauty Shop each had an affixed maintenance tag by an inspection contractor indicating the date the most recent annual maintenance was performed was January 2021. Based on interview at the time of the observations, the Director of Maintenance agreed it had been greater than twelve months since the most recent annual maintenance was documented on the aforementioned three portable fire extinguishers.	K 0355	POC- Life Safety Tag K355 SS-F **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents have been affected by the deficient practice, portable fire extinguisher monthly inspection documentations have been completed for medical record room, central supply room, beauty shop and main shut off electrical and water room. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No residents have been affected by the deficient practice, Audit for the all the potable fire extinguishers had been completed and all monthly inspection documentations have been completed for medical record room, central supply room, beauty shop and main shut off electrical and water room. **What measures will be put into**	11/24/2022

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	This finding was reviewed with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 4 of 18 portable fire extinguishers were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during a tour of the facility from 9:15 a.m. to 11:50 a.m. on 11/02/22,		**place and what systemic changes will be made to ensure that the deficient practice does not recur.** Maintenance director /Designee will complete random audits daily Monday through Sunday one times a week on random shifts including weekends for four weeks, then one times a week for two weeks, then one times a week for the one week to ensure portable fire extinguisher monthly inspection and documentation are complete. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicate **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Maintenance director /Designee will complete random audits daily Monday through Sunday one times a week on random shifts including weekends for four	

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	the affixed maintenance tags for the following ABC type portable fire extinguisher locations had missing monthly inspection documentation: a. in the Medical Records office in the A Wing short hall for August, September and October 2022. b. in the Central Supply room for August, September and October 2022. c. in the Beauty Shop for August, September and October 2022. d. in the Main Shut Off Electrical & Water for September and October 2022. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned portable fire extinguisher locations each had missing monthly inspection documentation. This finding was reviewed with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during the exit conference. 3.1-19(b)		weeks, then one times a week for two weeks, then one times a week for the one week to ensure portable fire extinguisher monthly inspection and documentation are complete. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated Date of compliance November 24th , 2022	
K 0362 SS=E Bldg. 01	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls			

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	are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____________ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7			
	Based on observation and interview, the facility failed to ensure corridor walls in 1 of 9 smoke compartments were constructed to resist the transfer of smoke. LSC 8.3.3.1 states fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage and sills shall be in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Openings Protectives. NFPA 80, 2010 Edition, Section 4.8.2.11 states for service counter fire doors, sills shall be provided as part of the fire door assembly. Section 4.8.2.2 states sills shall be constructed of noncombustible materials. Section 4.8.2.5 states for special-purpose horizontally sliding accordion or folding doors with frames having a jamb depth of 4 inches or less, the sill width shall be equal to the jamb depth. Section 5.2.5.2 states no open holes or breaks shall exist in surfaces of either the door or frame. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the main dining room. Findings include: Based on observations with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during a tour of the facility from 9:15 a.m. to 11:50 a.m. on 11/02/22, the main dining room was open to the corridor. The rolling fire door for the kitchen is in the west	K 0362	POC- Life Safety Tag K362 SS-E **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents have been affected by the deficient practice, but the rolling fire door for the kitchen is in the west wall of main dining room is now on track within the rolling door which caused the rolling door opening to resist the transfer smoke now. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No residents have been affected by the deficient practice, Audit for the all the fire-resistant doors in the facility had been made. No	11/24/2022

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	wall of the main dining room. The rolling fire door was off track and was not within the door frame for the rolling door which caused the rolling door opening to not resist the transfer of smoke. The Director of Maintenance tried to put the rolling door back on track within the rolling fire door frame at the time of the observations. Based on interview at the time of the observations, the Director of Maintenance agreed the rolling door had been off track and would not resist the passage of smoke. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference. 3.1-19(b)		other doors have the same deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Maintenance director /Designee will complete random audits daily Monday through Sunday one times a week on random shifts including weekends for four weeks, then one times a week for two weeks, then one times a week for the one week to ensure fire resistant doors resist the transfer of the smoke. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Maintenance director /Designee	

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			will complete random audits daily Monday through Sunday one times a week on random shifts including weekends for four weeks, then one times a week for two weeks, then one times a week for the one week to ensure fire resistant doors resist the transfer of the smoke. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated Date of compliance November 24th, 2022	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by			

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	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.			
	Based on observation and interview, the facility failed to ensure 4 of over 75 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 40 residents, staff and visitors. Findings include: Based on observations with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during a tour of	K 0363	POC- Life Safety Tag K363 SS-E **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents have been affected	11/24/2022

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	the facility from 9:15 a.m. to 11:50 a.m. on 11/02/22, the following was noted: a. the corridor door to Room A18 didn't latch into the door frame when tested to close multiple times because a hasp was affixed to the door and the door frame which didn't allow the latching mechanism on the door to protrude into the latching plate on the door frame. The Director of Maintenance removed the hasp which then allowed the door to latch into the door frame. b. wood was gouged out of the face of the corridor door to Room B23 by the door handle which exposed the latching mechanism on the door and did not ensure the door was 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Room B23 had been converted to a conference room. c. the corridor door to Room C10 was propped in the fully open position with a waste basket placed on the floor up against the door. d. two screws were missing on the metal plate holding the latching mechanism in place on the entry door to the kitchen from the Main Dining Room by the kitchen rolling fire door which caused the entry door to the kitchen to not latch into the door frame each time the door was tested to close multiple times. The Main Dining Room was open to the corridor. Based on interview at the time of the observations, the Director of Maintenance and the Corporate Maintenance Director agreed the aforementioned corridor doors had an impediment to closing and latching into the door frame or would not resist the passage of smoke or were not 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. This finding was reviewed with the Executive Director, the Director of Maintenance and the		by the deficient practice, but room no A18, B23,C10 and the entry door to the kitchen are all the doors are now fixed and can latch properly now. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No residents have been affected by the deficient practice, Audit for the all the doors in the facility had been made. No other doors have the same deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Maintenance director /Designee will complete random audits daily Monday through Sunday one times a week on random shifts including weekends for four weeks, then one times a week for two weeks, then one times a week for the one week to ensure doors latch properly. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or	

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	Corporate Maintenance Director during the exit conference. 3.1-19(b)		until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Maintenance director /Designee will complete random audits daily Monday through Sunday one times a week on random shifts including weekends for four weeks, then one times a week for two weeks, then one times a week for the one week to ensure doors latch properly. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated Date of compliance November 24th, 2022	

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K 0712 SS=F Bldg. 01	NFPA 101 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			
	1. Based on record review and interview, the facility failed to document quarterly fire drills or staff training documentation on fire drill procedures on the second shift for 2 of 4 quarters. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Fire/Disaster Drill" documentation, "Envive Healthcare Inservice Sign In" documentation and "2022 Fire Drill Schedule" documentation with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during record review from 9:20 a.m. to 1:45 p.m. on 11/01/22, documentation of a second shift fire drill or staff training documentation on fire drill procedures in the fourth quarter (October, November, December) 2021 and in the second quarter (April, May, June) 2022 was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility operates two	K 0712	POC- Life Safety Tag K712 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents have been affected by the deficient practice, but fire drills have been completed on second shift. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No residents have been affected by the deficient practice.	11/24/2022

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	shifts per day and agreed documentation of a fire drill or staff training on fire drill procedures for the second shift in the aforementioned calendar quarters was not available for review. This finding was reviewed with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to document the staff who participated in quarterly fire drills or staff training documentation on fire drill procedures on the second shift for 2 of 4 quarters. LSC Section 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. LSC Section 19.7.1.8 states employees of health care occupancies shall be instructed in life safety procedures and devices. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Fire/Disaster Drill" documentation, "Envive Healthcare Inservice Sign In" documentation and "2022 Fire Drill Schedule" documentation with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during record review from 9:20 a.m. to 1:45 p.m. on 11/01/22, documentation of the staff who participated in the second shift fire drills conducted on 03/31/22 at 6:00 p.m. and on 06/21/22 at 2:00 p.m. was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility operates two shifts per day and agreed documentation of the staff who participated in the		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Maintenance director /Designee will complete random audits daily Monday through Sunday one times a week on random shifts including weekends for four weeks, then one times a week for two weeks, then one times a week for the one week to ensure fire drills are completed on every shift per regulations. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Maintenance director /Designee will complete random audits daily Monday through Sunday one times a week on random shifts	

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	aforementioned two fire drills was not available for review. This finding was reviewed with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during the exit conference. 3.1-19(b) 3. Based on record review and interview, the facility failed to document the date second shift fire drills were conducted for one of four quarters within the most recent twelve month period. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Fire/Disaster Drill" documentation, "Envive Healthcare Inservice Sign In" documentation and "2022 Fire Drill Schedule" documentation with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during record review from 9:20 a.m. to 1:45 p.m. on 11/01/22, fire drill documentation for the second shift fire drill conducted at "3:00" for "Jan-Dec" 2022 did not record the day the drill was conducted. Based on interview at the time of record review, the Director of Maintenance stated the facility operates two shifts per day and agreed the aforementioned second shift fire drill documentation did not record the date the drill was conducted. This finding was reviewed with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during the exit conference.		including weekends for four weeks, then one times a week for two weeks, then one times a week for the one week to ensure fire drills are completed on every shift per regulations. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated Date of compliance November 24th, 2022	

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K 0761 SS=F Bldg. 01	Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, Section 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads	K 0761	POC- Life Safety Tag K761 F Level **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents have been affected by the deficient practice, but the facility annual inspection documentation of fire door assembly in the facility now includes all the doors in the facility which were missed in the report. Like kitchen rolling fire door, oxygen containing room **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No residents have been affected by the deficient practice, but audit of the document is made to ensure that all the required facility doors are inspected and documented.	11/24/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Maintenance Binder, Fire Doors, Explanation and Instructions" and "Fire" documentation with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during record review from 9:20 a.m. to 1:45 p.m. on 11/01/22, annual inspection documentation of fire door assemblies in the facility within the most recent twelve month period did not include all fire doors in the facility. Doors to oxygen storage rooms were not included in the listing of "Fire Door Location" in "Fire" documentation. In addition, the fire door		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Maintenance director /Designee will complete random audits daily Monday through Sunday four times a week on random shifts including weekends for four weeks, then three times a week for two weeks, then two times a week for the two weeks, once a week for one weeks to ensure that the facility annual inspection documentation of fire door assembly in the facility now includes all the door. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Maintenance director /Designee will complete random audits daily	

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	155077	A. BUILDING 01 B. WING	11/02/2022

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	explanation and instructions did not include all items in NFPA 80, Section 5.2.4.2. Annual inspection documentation for the kitchen rolling fire door was also not available for review. Based on interview at the time of record review, the Director of Maintenance stated he checks fire doors in the facility on a monthly basis for the items stated in the explanation and instruction documentation. Based on observations with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during a tour of the facility from 9:15 a.m. to 11:50 a.m. on 11/02/22, the facility has one oxygen storage and transfilling room inside the facility near the entrance to the main dining room. Five liquid oxygen containers and fifteen 'E' type oxygen cylinders were stored in the room. The entry door to the room had a 1-hour fire resistance rating label affixed to the hinge side of the door. In addition, the rolling fire door in the kitchen had a 3-hour fire resistance rating label affixed to the door. A contractor had affixed an annual inspection sticker to the door assembly but the date of the most recent inspection was not legible. Based on interview at the time of record review and of the observations, the Director of Maintenance agreed it could not be ensured all fire door locations in the facility were included in the inspection documentation and the inspection documentation included all items in NFPA 80. This finding was reviewed with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during the exit conference. 3.1-19(b)		Monday through Sunday four times a week on random shifts including weekends for four weeks, then three times a week for two weeks, then two times a week for the two weeks, once a week for one weeks to ensure that the facility annual inspection documentation of fire door assembly in the facility now includes all the doors. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated Date of compliance November 24th , 2022	
K 0918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste			

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Bldg. 01	Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for the facility's diesel-powered generator. NFPA 99, Health Care Facilities Code,	K 0918	POC- Life Safety Tag K918 F Level	11/24/2022

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	2012 Edition, Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director from 9:20 a.m. to 1:45 p.m. on 11/01/22, documentation of an annual fuel quality test for the diesel fired emergency generator was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility has one diesel fired emergency generator and agreed documentation of an annual fuel quality test for the diesel fired emergency generator was not available for review. This finding was reviewed with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to document 36 month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents have been affected by the deficient practice, but the facility has started annual fuel quality test for diesel fired emergency generator and four continuous hour supplemental load testing has been started. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No residents have been affected by the deficient practice, but facility had inspected the generator and started the working on missing documentation. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Maintenance director /Designee will complete random audits daily Monday through Sunday four times a week on random shifts including weekends for four weeks, then three times a week for two weeks, then two times a week for the two weeks, once a	

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	Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director from 9:20 a.m. to 1:45 p.m. on 11/01/22, thirty-six month period emergency generator testing documentation for four continuous hours for the diesel fired emergency generator was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility has one diesel fired emergency generator and agreed documentation of supplemental load testing for four hours within the most recent three year period was not available for review. Based on observations with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during a tour of the facility from 9:15 a.m. to 11:50 a.m. on 11/02/22, the facility has one diesel fired emergency generator located		week for one weeks to ensure the diesel fired emergency generator documents are maintained per regulation. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Maintenance director /Designee will complete random audits daily Monday through Sunday four times a week on random shifts including weekends for four weeks, then three times a week for two weeks, then two times a week for the two weeks, once a week for one weeks to ensure that the diesel fired emergency generator documents are maintained per regulation.Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be	

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	outside the building in its own walk-in weatherproof shell. Manufacturer's nameplate rating for the generator stated it was rated at 600 kW. This finding was reviewed with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during the exit conference. 3.1-19(b)		reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated Date of compliance November 24th, 2022	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembes that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5			

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	Based on observation and interview, the facility failed to ensure 1 of 1 extension cords were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the B Wing nurse's station pantry. Findings include: Based on observations with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during a tour of the facility from 9:15 a.m. to 11:50 a.m. on 11/02/22, a refrigerator was plugged into an extension cord in the pantry at the B Wing nurse's station. Based on interview at the time of the observations, the Director of Maintenance agreed an extension cord was being used as a substitute for fixed wiring at the aforementioned location. This finding was reviewed with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during the exit conference. 3.1-19(b)	K 0920	POC- Life Safety Tag K920 E Level **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents have been affected by the deficient practice, but the facility has removed the extension cord in the pantry in B wing and replaced it with fix wiring. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No residents have been affected by the deficient practice, but facility had audited all the areas to ensure there is no extension cords in any other areas of the facility. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Maintenance director /Designee will complete random audits daily Monday through Sunday four times a week on random shifts	11/24/2022

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			including weekends for four weeks, then three times a week for two weeks, then two times a week for the two weeks, once a week for one weeks to ensure that there is no extension cords in the building per regulations. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Maintenance director /Designee will complete random audits daily Monday through Sunday four times a week on random shifts including weekends for four weeks, then three times a week for two weeks, then two times a week for the two weeks, once a week for one weeks to ensure that that there are no extension cords in the building per regulations. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be	

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			reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated Date of compliance November 24th, 2022	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet 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. Less than or equal to 300 cubic feet 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			

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	as specified in 11.6.2. 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." Storage is planned so cylinders are used in order of which they are received from the supplier. 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. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 1 of 15 cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 2 oxygen storage areas. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.1 states storage for nonflammable gases equal to or greater than 85 cubic meters (3000 cubic feet) shall comply with 5.1.3.3.2 and 5.1.3.3.3. NFPA 99, Section 5.1.3.3.2(7) requires cylinders be provided with racks, chains, or other fastenings to secure all cylinders from falling, whether connected, unconnected, full or empty. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room near the main dining room. Findings include: Based on observations with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during a tour of the facility from 9:15 a.m. to 11:50 a.m. on 11/02/22,	K 0923	POC- Life Safety Tag K923 E Level **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents have been affected by the deficient practice, but the facility has secured one of that nonflammable gases oxygen storage cylinders properly **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.**	11/24/2022

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	one of fifteen 'E' type oxygen cylinders were freestanding on the floor near the corridor door to the oxygen storage and transfilling room near the main dining room and was not properly secured from falling. Five liquid oxygen containers and fifteen 'E' type oxygen cylinders were stored in the room. Based on interview at the time of the observations, the Corporate Maintenance Director agreed the oxygen cylinder was not supported in a cylinder stand or otherwise secured from falling in the oxygen storage and transfilling room and placed it in a cylinder storage rack in the room. This finding was reviewed with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during the exit conference. 3.1-19(b)		No residents have been affected by the deficient practice, but the facility had audited all the areas to ensure there is no loose oxygen storage cylinders unsecured in the building. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Maintenance director /Designee will complete random audits daily Monday through Sunday four times a week on random shifts including weekends for four weeks, then three times a week for two weeks, then two times a week for the two weeks, once a week for one weeks to ensure that there is no unsecured oxygen cylinders in the building. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put into place; and Maintenance director /Designee will complete random audits daily Monday through Sunday four times a week on random shifts including weekends for four weeks, then three times a week for two weeks, then two times a week for the two weeks, once a week for one weeks to ensure that that there are no unsecured oxygen cylinders in the building. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated Date of compliance November 24th, 2022	