STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155845	A. BUILDING -- B. WING	05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(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: 05/04/23 Facility Number: 000368 Provider Number: 155845 AIM Number: 100275220 At this Emergency Preparedness survey, Simmons Loving Care Health Facility was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 46 certified beds. At the time of the survey, the census was 20. Quality Review completed on 05/08/23	E 0000		
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathy Jones	Interim Administrator	06/21/2023

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.

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	§491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:			

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	(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.			
	Based on record review and interview, the facility failed to maintain an Emergency Preparedness Plan (EPP) that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants. Findings include: Based on records review with the Director of Nursing (DON) on 05/04/23 between 09:18 a.m. and 11:32 a.m., no documentation could be found regarding a documented facility-based and community-based risk assessment utilizing an all-hazards approach. Based on interview at the	E 0006	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents were found to be affected by the deficient practice; however, all residents had the potential to be affected. The risk assessment was completed by the QA committee on 6/21/2023 using the Indiana LTC form "hazard vulnerability".** 2. 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; **All residents were identified as**	06/23/2023

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	time of record review, the DON stated the facility has a documented risk assessment that is with the Emergency Preparedness Plan, but was unable to be located at the time of the survey. This finding was reviewed with the DON during the exit conference.		**being potentially affected by the deficient practice. The Hazard Vulnerability Risk Assessment was placed in the emergency preparedness binder and reviewed by the QA team on 6/21/2023.** 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **The custodians and administration were educated by the interim administrator including the placement of the risk assessment as well as the need to update it with any changes or at least every 2 years. The administrator and or designee will ensure that the Hazard Vulnerability Risk Assessment is located in the emergency preparedness binder at the nurse's station** 4. 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 **The Administrator or designee will conduct a monthly audit for 6 months to ensure that the Risk Assessment continues to be located in the emergency preparedness binder at the nurse's station. The Administrator will present findings to the QA committee**	

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			each month to ensure continued compliance.	
E 0022 SS=F Bldg. --	403.748(b)(4), 416.54(b)(3), 418.113(b)(6)(i), 441.184(b)(4), 482.15(b)(4), 483.475(b)(4), 483.73(b)(4), 485.625(b)(4), 485.68(b)(2), 485.727(b)(2), 485.920(b)(3), 491.12(b)(2), 494.62(b)(3) Policies/Procedures for Sheltering in Place §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients,			

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	hospice employees who remain in the hospice. Based on record review and interview, the facility failed to ensure that shelter in place policies were documented in emergency preparedness plans in accordance to 42 CFR 483.475(b)(4).This deficient practice could impact all occupants. Findings include: Based on record review with the Director of Nursing (DON) on 05/04/23 between 09:18 a.m. and 11:32 a.m., the facility did not have a shelter in place policy designed for emergency preparedness plans. During an interview at the time of record review, the DON acknowledged the aforementioned documentation and stated that the facility has a shelter-in-place policy, but was unable to be located at the time of record review. Findings were discussed with DON at exit conference.	E 0022	1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents were found to be affected by the deficient practice; however, all residents had the potential to be affected. The shelter in Place Policy and procedures were reviewed by the QA committee on 6/21/2023 and placed in the emergency preparedness binder at the nurses station.** 2. 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 were found to be affected by the deficient practice; however, all residents had the potential to be affected. The shelter in Place Policy and procedures were reviewed by the QA committee on 6/21/2023 and placed in the emergency preparedness binder at the nurses station** 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **The maintenance/custodial staff were educated on the requirement to ensure the**	06/23/2023

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			facility has a Shelter In Place Policy and Procedure as part of their emergency preparedness binder by the interim administrator on 6/21/2023. 4. 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 **The administrator or designee will conduct monthly audits for 6 months as part of the monthly environmental rounds to ensure the Shelter In Place Policy and Procedures continue to be placed in the emergency preparedness binder. The Administrator will present the findings of the rounds to the QA committee monthly to ensure continued compliance.**	
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: 05/04/23 Facility Number: 000368 Provider Number: 155845 AIM Number: 100275220 At this Life Safety Code survey, Simmons Loving Care Health Facility was found not in compliance	K 0000		

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	with Requirements for Participation in Medicare and 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. This one-story facility with a partial basement, built in 1967, was determined to be of Type II (111) construction and was fully sprinklered. The facility has a monitored fire alarm system with smoke detection in the corridors and spaces open to the corridor. The facility has no emergency power protection. Twenty resident rooms were provided with battery operated smoke detectors. The facility has the capacity for 46 and had a census of 20 at the time of this survey. All areas accessible to residents and areas providing facility services were sprinklered. Quality Review completed on 05/08/23			
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 accordance with 7.9. 18.2.9.1, 19.2.9.1 1. Based on records review and interview, the facility failed to ensure 10 of 10 battery backup lights were tested monthly. Section 7.9.3.1.1 (1) requires 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 and (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	K 0291	1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents were affected by this deficient practice. The 2 defective battery-operated emergency lights were replaced by 5/11/2023. April documentation was noted on**	06/23/2023

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	building occupants when work is needed in the transfer switch room during a power outage. Findings include: Based on record review during a tour of the facility with the Director of Nursing (DON) on 05/04/23 between 09:18 a.m., documentation of a monthly 30 second test for the battery powered emergency light was provided, but there was no information provided that indicated a monthly 30-second inspection for April 2023 was conducted. Based on an interview at the time of record review, the DON stated they were in touch with maintenance personnel and was told the inspections were done, but did not get signed off on the inspection log. This finding was reviewed with the DON during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 10 battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect approximately 20 residents and staff. Findings include:		**the inspection logs immediately when the Maintenance Director was notified.** 2. 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; **All residents had the potential to be affected by the deficient practice; however, none were affected. The 2 battery-operated emergency lights were replaced by 5/11/2023.** 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Maintenance/custodial staff were educated by the interim administrator on 6/21/2023 related to monthly documentation of all battery-operated emergency lighting that must be routinely checked per the NFPA 101 regulations. The education includes proper documentation and record keeping to ensure life safety documentation is available upon request.** 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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	Based on observation with the Director of Nursing (DON) on 05/04/23 between 11:50 a.m. and 12:55 p.m., the battery-operated emergency lights in the dining area next to the kitchen entrance/exit doors did not work when tested. Based on interview at the time of the observations, the DON agreed the battery-operated emergency lights failed to function when its respective test button was pushed and stated the emergency lights will be replaced later this week. The findings were reviewed with the DON during the exit conference. 3.1-19(b)		program will be put into place **The administrator or designee will audit the life safety binder documentation monthly for 6 months to ensure the routine monthly inspections of the 10 battery-operated Emergency lighting are documented timely and accurately. The administrator will present findings of these audits to the QA committee monthly to ensure continued compliance for at least 6 months.**	
K 0300 SS=C 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. Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of 20 of 20 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. NFPA 72, 29.10 Maintenance and Tests. 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,	K 0300	1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents were found to be affected by the deficient practice; however, all residents, staff and visitors had the potential to be affected. The smoke detectors were retested in May and logged accordingly on the log sheets**	06/23/2023

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	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 records review with the Director of Nursing (DON) on 05/04/23 between 09:18 a.m. and 11:32 a.m., documentation for monthly inspections for all battery-operated smoke detectors was able to be presented during the survey, but a monthly inspection for April 2023 was not documented. Based on interview at the time of review, the DON stated she was able contact maintenance personnel who stated the checks were done, but did not document the checks on the monthly inspection sheets. Findings were discussed with the DON at the exit conference. 3.1-19(b)		**in addition to the April 2023 documentation by 5/11/2023 by the maintenance director when made aware.** 2. 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 were found to be affected by the deficient practice; however, all residents, staff and visitors had the potential to be affected. The smoke detectors were retested in May and logged accordingly on the log sheets in addition to the April 2023 documentation by 5/11/2023 by the maintenance director when made aware.** 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **The maintenance director and designee was educated by the interim administrator regarding the deficient practice and importance of documentation of the monthly inspection of smoke detector testing on 6/21/2023.** 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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			program will be put into place **The administrator or designee will audit the life safety binder documentation monthly for 6 months to ensure the routine monthly testing of all battery-operated smoke detectors are documented timely. The administrator will present findings of these audits to the QA committee monthly to ensure continued compliance for at least 6 months.**	
K 0321 SS=D 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			

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	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 (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 the corridor doors to 1 of 4 hazardous rooms were provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect approximately 5 staff and an unknown amount of residents. Findings include: Based on observations during a tour of the facility with the Director of Nursing (DON) on 05/04/23 between 11:50 a.m. and 12:55 p.m., the corridor door to the storage room in the basement across from the food pantry room did not self-close. The room measured approximately 60 square feet, had over 20 cardboard boxes of PPE and patient care items. Based on interview at the time of observation, the DON acknowledged the amount of combustible material within the room; that room was larger 50 square feet; and the door did not self close. . This finding was reviewed with the DON during the exit conference. 3.1-19(b)	K 0321	1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents were found to be affected by the deficient practice; however, all residents could have been affected. New spring hinges were purchased and installed by 6/5/2023 to ensure the storage room corridor door met the hazardous area Enclosure guidelines.** 2. 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; **A round of all potential areas needing self closure mechanism was conducted by the interim administrator on 6/21/2023 and list given to ownership in QA meeting. More spring hinges will be ordered for other doors needing a self-closure mechanism to be installed**	06/23/2023

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	155845	A. BUILDING 01 B. WING	05/04/2023

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			upon delivery. 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Administration and maintenance/custodial staff were educated on 6/21/2023 regarding the use of self closure mechanisms in hazardous areas. New maintenance staff will be educated as well upon hire during emergency preparedness rounds with administrator or designee.** 4. 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 **The maintenance director or designee will conduct monthly checks on doors leading to hazardous areas and supply storage closets and document according. The administrator or designee will check monthly documentation to ensure it is completed timely for 6 months. Findings will be presented to the QA committee monthly to ensure continued compliance.**	
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			

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	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 Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. 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. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly.	K 0353	1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No resident found to be affected; The quarterly sprinkler test was conducted on 5/1/2023 and is scheduled to be conducted again before the end of June for quarter 2.** 2. 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; **All residents were potentially affected. The quarterly sprinkler test was conducted on 5/1/2023 with no abnormal findings and is scheduled to be conducted again by the end of June to stay on schedule for Q2.** 3. what measures will be put into	06/23/2023

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	5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the quarterly sprinkler system inspection records with the Director of Nursing (DON) on 05/04/23 between 09:18 a.m. and 11:32 a.m., there was no quarterly sprinkler system inspection report available for the first quarter (January, February and March) of 2023. During an interview at the time of record review, the DON acknowledged there was no written documentation available to show the sprinkler system had been inspected during the first quarter of 2023 and stated that the contracted sprinkler company did not do an inspection during the first quarter and was going to be conducting two inspections during second quarter to make up the missed inspection. Findings were discussed with the DON during the exit conference. 3.1-19(b)		place and what systemic changes will be made to ensure that the deficient practice does not recur; **The Interim administrator and Owner spoke with Safecare and set up a portal access to ensure improved communication ongoing to ensure all inspections were scheduled and completed timely. Interim administrator educated maintenance director and designee of importance of life safety required documentation requested upon entrance be made available. Life Safety binder reorganized on 6/21/2023 for a better filing system to ensure timeliness. Maintenance director educated on 6/21/2023 on these processes and portal access.** 4. 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 **Administrator will include the quarterly documentation on monthly audits to ensure that the sprinkler inspections are included and discussed in QA as well. Quarterly inspections to be audited for completion monthly for 6 months to include June through December inspections. Administrator will present findings of monthly audits to the QA committee to**	

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			ensure continued compliance through the remainder of the year.	
K 0500 SS=C Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services 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. Based on record review, observation, and interview, the facility failed to ensure 1 of 1 water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect approximately 10 staff and an unknown number of residents. Findings include: Based on observation during a tour of the facility with the Director of Nursing (DON) on 05/04/23 between 11:50 a.m. and 12:55 p.m., one water heater located in the basement did not have a certificate posted on the water heater. Based on record review between 09:18 a.m. and 11:32 a.m., a water heater inspection certificate was available for review, but the expiration date was dated 05/03/21. Based on interview at the time of record review and observation, the DON stated that the insurance company used to do inspections, but	K 0500	1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents were found to be affected by the deficient practice; The facility is working with the insurance company and other appropriate parties to schedule the inspections and gain the certificates as soon as inspected. Insurance company was contacted and they will make arrangements for the boiler inspections then ownership can renew the certification online.** 2. 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 were found to be affected by the deficient**	06/23/2023

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	the company stopped inspections and was unable to get inspections scheduled before the indicated expiration date. Findings were reviewed with the DON at exit conference. 3.1-19(b)		**practice; however, all residents had the potential to be affected. The facility is working with the insurance company and other appropriate parties to schedule the inspections and gain the certificates as soon as inspected. Insurance company was contacted and they will make arrangements for the boiler inspections then ownership can renew the certification online.** 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Owner and maintenance staff educated on the process for water heater/boiler inspections on or before 6/21/2023 by the interim administrator. The owner will continue to be in contact with the insurance company daily with follow up requested by interim administrator to ensure scheduling of the inspection occurs as soon as possible.** 4. 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 **Administrator will follow up at least weekly ongoing until inspection completed and**	

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			certificates placed in life safety binder. Once the inspection is completed, the administrator will include the water heater inspections documentation on the monthly environmental round audit form. The administrator will present findings to the QA committee monthly for 6 months to ensure compliance. The inspection due date will be placed also on the inspection log tool notifying the maintenance director when each inspection is due next.	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure electrical wiring in 1 of 1 Janitor's Closet was protected. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect approximately 3 staff. Findings include: Based on observation during a tour of the facility with the Director of Nursing on 05/04/23 between 11:50 a.m. and 12:55 p.m., in the Janitor closet next to resident room 108 had a broken light fixture.	K 0511	1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents were found to be affected by the deficient practice. A new light fixture was purchased and installed immediately on or before 5/11 by the maintenance director.** 2. how other residents having the potential to be affected by the same deficient practice will be	06/23/2023

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	The light bulb was hanging off of the wall and had wiring exposed wiring coming from the wall where the mount used to be. Based on interview at the time of observation, the DON stated they were unaware of the deficiency and would start the process to repair the fixture. This finding was reviewed with the DON at the exit conference. 3.1-19(b)		identified and what corrective action(s) will be taken; **No residents were found to be affected by the deficient practice; An audit of the facility was conducted on 6/22/2023 by maintenance and interim administrator looking for exposed wiring and other electrical hazards.** 3. 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 and designee was educated by the interim administrator on the importance of routine rounding to ensure all areas are safe for staff and residents. All staff will be educated by 6/23/2023 to ensure work orders are available for all staff to fill out and communicate the need for an item to be fixed timely. Maintenance Director will monitor exposed wiring monthly during environmental rounds.** 4. 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 **Administrator or designee will conduct monthly audits of the required documentation in life safety binder for 6 months to**	

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			include work orders and timely completion especially when causing a risk to residents and staff. Work orders will be discussed with owners daily or as needed. Administrator will discuss findings in QA meeting monthly for 6 months to ensure continued compliance.	