STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155733	A. BUILDING -- B. WING	05/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL NURSING HOME	119 N INDIANA AVE CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/24/2021 Facility Number: 000360 Provider Number: 155733 AIM Number: 100290370 At this Emergency Preparedness survey, Colonial Nursing Home was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 55 certified beds. At the time of the survey, the census was 38. Quality Review completed on 05/27/21	E 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. Colonial Nursing and Rehab requests that the plan of correction be considered our allegation of compliance effective June 23, 2021 to the Life Safety survey conducted on May 24, 2021 and request paper compliance.	
E 0039 SS=C Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727,			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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COLONIAL NURSING HOME	119 N INDIANA AVE CROWN POINT, IN 46307

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	CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise			

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	the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice			

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

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

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

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

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

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

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	of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. The ICF/IID facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may	E 0039	**E039- EP Testing Requirements** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* *No residents were harmed by the alleged deficient practice.* *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* All residents had the potential to be harmed by alleged deficient practice. An audit of emergency procedure binders was done by the Administrator facility wide to ensure that all are up to date.	06/23/2021

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	include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants. Findings include: During record review with the Maintenance Director on 05/24/2021 at 10:45 a.m. the facility provided documentation for it's response to the COVID-19 Public Health Emergency, however could not provide documentation of an additional exercise of choice to test the emergency preparedness plan. Based on interview at the time of record review, the Maintenance Director agreed that they only have documentation for the response to the COVID-19 Public Health Emergency, and could not provide documentation of an additional exercise of choice within the most recent year. This deficient practice was reiewed with the Administrator at the time of exit.		There are 9 binders accessible to staff/residents/visitors throughout the building. It was reviewed in All Staff as recently as 5/18/21. *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur?* *A minimum of 2 full scale drills or tabletop exercises will be completed over the next year. The facility is a member of District 1 Emergency Management Committee. We will work in conjunction with them to complete any necessary exercises. The facility has created a binder of relevant drills based on our Hazard Vulnerability Assessment that will be used as a resource for drills.* *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 emergency management binder will be reviewed at least quarterly at the QA Meeting to ensure that it is up-to-date and that plans for drills are being discussed. *By what date the systemic changes will be completed?* **6/23/21**	

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey were conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/24/2021 Facility Number: 000360 Provider Number: 155733 AIM Number: 100290370 At this Life Safety Code survey, Colonial Nursing Home 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. This facility is a two story fully sprinklered building determined to be Type V (111) construction with a lower level located in the basement with additions and updates made prior to March 1, 2003. The facility has a fire alarm system with hard wired smoke detection in the corridors, spaces open to the corridors, and C hall first floor resident rooms. All other resident rooms are equipped with battery powered smoke detectors. The building is partially protected by a Natural Gas fueled 12kW generator. The facility has the capacity for 55 dually certified beds and had a census of 38 at the time of this survey. All areas where the residents have customary	K 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. Colonial Nursing and Rehab requests that the plan of correction be considered our allegation of compliance effective June 23, 2021 to the Life Safety survey conducted on May 24, 2021 and request paper compliance.	

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	access and areas providing facility services were sprinklered. Quality Review completed on 05/27/21			
K 0345 SS=D Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation the facility failed to maintain 1 of 1 smoke detectors in the boiler room in accordance with NFPA 72, National Fire Alarm and Signaling Code, Section 17.4.4. Section 17.4.4 states that initiating devices shall be supported independently of their attachment to the circuit conductors. This deficiency affects staff only. Findings include: During a facility tour with the Maintenance Director on 05/24/2021 at 10:55 a.m. a smoke detector in the boilerroom was supported only by the conductors. Based on interview at the time of observation, the Maintenance Director agreed that the smoke detector was supported only by the conductors. This deficiency was reviewed with the Administrator at the time of exit.	K 0345	**K345 Fire Alarm System-Testing and Maintenance** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* *No residents were harmed by the alleged deficient practice. The identified detector was properly secured to the base independent of its attachments.* *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* A facility wide audit of smoke detectors was completed by the Maintenance Director to ensure that all were properly attached to their base and any deficiencies	06/23/2021

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	3.1-19(b)		were immediately corrected. *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur?* An inservice was done with the Director of Maintenance on the proper securing of smoke detectors. *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?* A performance improvement tool was created that will audit 5 random smoke detectors in the building each week for 3 months and then bi-weekly for an additional 3 months. Above audit tool to be reviewed in the QA meeting at least quarterly. *By what date the systemic changes will be completed?* **6/23/21**	
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			

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	_____ 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 maintain 1 of 1 automatic sprinkler systems in accordance with NFPA 25, "Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems", Section 5.3.4 which states that The freexing point of solutions in antifreeze shall be tested annually by measuring the specific gravity with a hydrometer or refractometer and adjusting the solutions if necessary . This deficient practice could affect all residents, staff and visitors. Findings include: During record review with the Maintenance Director on 05/24/2021 at 9:55 a.m., the sprinkler inspection, titled "Report of Inspection" and dated 02/09/2021 indicated that the antifreeze was tested at 9 and 11 degrees Fahrenheit. The facility was unable to provide documentation that the antifreeze was adjusted. Based on interview at the time of record review, the Maintenance Director agreed that the antifreeze was out of range for the facility's geography. This deficient finding was reviewed with the Administrator at the time of exit. 3.1-19(b)	K 0353	**K353- Sprinkler system-Maintenance and Testing** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* *No residents were harmed by the deficient practice.* *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* All residents had the potential to be harmed by the alleged deficiency in colder weather. *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur?* The Maintenance Director was given an in-service on appropriate antifreeze freezing points per Life Safety Code. The technician from SafeCare was out on 5/25/21 for the quarterly inspection. He confirmed the temps of 9 and 11 degrees (report not yet available for download). SafeCare reports	06/23/2021

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			that they typically do not adjust the solution until the freezing point get above 15 degrees. They are preparing a quote to lower the freezing point of the solution. *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 temperature of the antifreeze freezing point will be monitored quarterly at the time if the Safecare inspection. Any temperatures above negative readings will be adjusted by the monitoring company. The result of the inspection will be discussed at least quarterly to monitor for any deficiencies. *By what date the systemic changes will be completed?* **6/23/21**	
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 CMS regulation. These requirements do not			

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	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 1 of over 100 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke in accordance with LSC 19.3.6.3. This deficient practice could affect up to 10 residents, staff and visitors near Resident Room 111. Findings include: During a facility survey with the Administrator and Maintenance Director on 05/24/2021 at	K 0363	**K363 Corridor- Doors** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* *No residents were harmed by the alleged deficient practice. The door knob on room 111 was swapped with a new door knob which properly latched each time it was tested.* *How the facility will identify other*	06/23/2021

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	11:10 a.m., the corridor door to Resident Room 111 failed to latch when tested multiple times. Based on interview at the time of observation, the Maintenance Director agreed that the door to Resident Room 111 failed to latch. This deficient finding was reviewed with the Administrator at the time of exit. 3.1-19(b)		*residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* A facility wide audit of corridor doors was completed by the Maintenance Director and any deficiencies were immediately corrected. *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur?* An inservice was done with the Director of Maintenance on the proper securing of corridor doors and smoke/fire protection. *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?* A performance improvement tool was created that will audit 10 random corridor doors in the building each week for 3 months and then bi-weekly for an additional 3 months. Above audit tool to be reviewed in the QA meeting at least quarterly. *By what date the systemic changes will be completed?* **6/23/21**	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie			

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	Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure 2 of 2 smoke barrier walls in the basement was maintained in accordance with LSC Section 19.3.7.5. Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. Section 8.5.2 states that smoke barriers shall be continuous from outside wall to outside wall and continuous through all concealed spaces. This deficient practice could affect staff only. Findings include: During a tour of the facility with the Maintenance Director on 05/24/2021 at 11:25 a.m. the West Basement smoke barrier was found to have a 1 inch annular gap around piping. Then, at 11:27 a.m., the South Basement smoke barrier had a 1/2 inch gap around communications cabling. Based on interview at the time of each observation, the Maintenance Director confirmed the non-sealed penetrations. This deficient finding was reviewed with the Administrator at the time of exit.	K 0372	**K372 Subdivision of Building Spaces- Smoke Barrier Construction** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* *No residents were harmed by the alleged deficient practice. The Maintenance Director sealed the area that was identified with the appropriate fire caulk material.* *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* A facility wide audit of smoke barriers was completed by the Maintenance Director and any deficiencies were immediately corrected. *What measures will be put into place or what systematic changes the facility will make to*	06/23/2021

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	3.1-19(b)		*ensure the deficient practice does not recur?* An inservice was done with the Director of Maintenance on the proper appearance and sealing of smoke barriers and smoke/fire protection. *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?* A performance improvement tool was created that will audit 2 smoke barriers in the building each week for 3 months and then bi-weekly for an additional 3 months. Above audit tool to be reviewed in the QA meeting at least quarterly. *By what date the systemic changes will be completed?* **6/23/21**	
K 0511 SS=E 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 protect 1 of 1 electrical panel in accordance with NFPA 70, the National Electrical Code. Section 110.27 Guarding of Live Parts. (A) Live Parts Guarded Against Accidental Contact. Except as elsewhere	K 0511	**K511 Utilities- Gas and Electric** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*	06/23/2021

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	required or permitted by this Code, live parts of electrical equipment operating at 50 volts or more shall be guarded against accidental contact by approved enclosures or by any of the following means: (1) By location in a room, vault, or similar enclosure that is accessible only to qualified persons. This deficient practice could affect staff and up to 10 residents. Findings include: During a tour of the facility with the Administrator and Maintenance Director on 05/24/2021 at 11:05 a.m. the electrical panel near resident room 121 was not secured. Based on interview, the Administrator and Maintenance Director stated that residents had access to the area and the unlocked panel would be a hazard. This deficient finding was reviewed with the Administrator at the time of exit. 3.1-19(b)		*No residents were harmed by the alleged deficient practice. The Maintenance Director installed a locking device onto the identified electrical panel prohibiting access unless a key was available.* *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* A facility wide audit of electrical panels was completed by the Maintenance Director and any deficiencies were immediately corrected. *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur?* An inservice was done with the Director of Maintenance on the proper sealing of electrical and utility panels. *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?* A performance improvement tool was created that will audit 3 random electrical panels in the building each week for 3 months and then bi-weekly for an additional 3 months. Above audit tool to be reviewed in the QA meeting at least quarterly.	

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			By what date the systemic changes will be completed? **6/23/21**	
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 Based on record review and interview, the facility failed to conduct 5 of 12 quarterly shift fire drills during the most recent 12 month time period. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. During the COVID-19 Public Health Emergency, authorized training could be used in lieu of fire drills. This deficient practice affects all staff and residents. Findings include: During record review with the Maintenance Director on 05/24/2021 at 9:50 a.m., the facility was unable to provide documentation of a fire drill for the 2nd and 3rd shift for the Second Quarter of 2020 or 2021; the 1st, 2nd, 3rd shift for the third quarter of 2020. Based on interview at the time of record review, the Maintenance Director stated that he began in October, 2020 and could provide no documentation of fire drills	K 0712	**K712 Fire Drills** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* *No residents were harmed by the alleged deficient practice.* *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* *A review of the current year's fire drills was conducted by the Director of Maintenance to ensure that all were conducted in the proper time frame. The final drill for the quarter will be completed prior to 6/23/21.* *What measures will be put into*	06/23/2021

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	or authorized training prior to that month. This deficient finding was reviewed with the Administrator at the time of exit. 3.1-19(b) 3.1-51(c)		*place or what systematic changes the facility will make to ensure the deficient practice does not recur?* *The Director of Maintenance received an inservice on fire drill procedure and timing.* *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 Director of Maintenance/Designee will perform a monthly audit of fire drills to ensure that drills were conducted and the next month's drills are scheduled. Any missed drills will be made up during the current quarter to ensure compliance. The audit will be reviewed at least quarterly in the QA meeting to ensure that all drills are being conducted in the appropriate timeframe.* *By what date the systemic changes will be completed?* 6/23/21	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste 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			

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	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 maintain a complete written record of monthly generator load testing for 5 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a	K 0918	**K918 Electrical Systems-Essential Electrical System Maintenance and Testing** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* *No residents were identified or harmed by the alleged deficient practice. The generator received its weekly test on 5/31/21 and is functioning properly.*	06/23/2021

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	written record of inspections, performance parameters, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 05/24/2021 at 9:40 a.m., documentation for testing for dates prior to October, 2020 were not available for review. Based on an interview at the time of record review, the Maintenance Director stated he began in October, 2020 and could provide no documentation prior to that month. This deficient finding was reviewed with the Administrator at the time of exit. 3.1-19(b) 2) Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants.		*How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* A facility wide audit was done which showed all generator testing since October 2020 was up to date. This included inspections by SafeCare, the generator service company. Safecare was also contacted to schedule a 4 hour lode bearing test which will be done prior to 6/23/21. *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur?* The maintenance director received an in-service on generator testing requirements. *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?* A performance improvement tool was created that will be done weekly for 3 months and then bi-weekly for 3 months to ensure that all testing is completed in the recommended timeframe. Above audit tool to be reviewed in the QA meeting at least quarterly. *By what date the systemic changes will be completed?* **6/23/21**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155733	A. BUILDING 01 B. WING	05/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	Findings include: During record review with the Maintenance Director on 05/24/2021 at 9:40 a.m., the facility provided documentation for testing of the emergency generator, however could not provide documentation of a three year 4 hour test. This was confirmed by the Maintenance Director. This deficient finding was reviewed with the Administrator at the time of exit. 3.1-19(b)			