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	09/07/2022

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

(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
K 0000 Bldg. 01	A Post Survey Revisit was conducted on the Life Safety Code Recertification and State Licensure Survey conducted by the Indiana Department of Health on 06/06/22 in accordance with 42 CFR 483.90(a). Survey Date: 09/07/2022 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. Colonial Nursing Home is a two-story building with a basement of Type V (000) construction that was built at three different times. The original building was constructed in 1906 with additions constructed in 1986 and 1994. The building is fully sprinklered and there is supervised smoke detection located in some of the corridors, some spaces open to the corridors and in some resident rooms. Battery operated smoke detectors are located in some of the corridors, some spaces open to the corridors and in some resident rooms. The facility has 55 certified beds. All 55 beds are dually certified for Medicare and Medicaid. At the time of the survey, the census was 35.	K 0000		

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 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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	All areas where the residents have customary access and areas providing facility services were sprinklered. Quality Review completed on 09/13/22			
K 0161 SS=F Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section			

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	9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. Based on interview and record review, the facility was not an acceptable type of construction as required by NFPA 101 - 2012 edition, Sections 19.1.6.1, 4.5.8 and NFPA 220 - 2012 edition, Section 4.1, 4.1.1 and Table 4.1.1. This deficient practice could affect all 35 residents. Findings include: Based on record review with the Interim Administrator and Maintenance Director on 09/07/22 from 9:15 a.m. to 12:30 p.m., the facility was determined to be Type V(000) construction as evident by the unprotected wood structure and the building was two stories. Type V (000) is not an acceptable type of construction for a two-story existing healthcare building. Based on record review of the facility's plan of correction, the facility planned to upgrade the fire alarm system prior to 09/05/22 in order to achieve a passing score on the FSES conducted on 06/29/22. Based on an interview with the Interim Administrator at the time of record review, the facility had not completed the fire alarm system upgrades. This finding was reviewed with the Interim Administrator at the exit conference at 11.49 a.m. This deficiency was cited on 06/06/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)	K 0161	**K225 Stairways and Smokeproof Enclosures** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* *Requesting compliance with alleged deficiency through the Life Safety Equivalency granted through the FSES once all required work in the FSES is complete and a passing score is achieved. These stairs would only be used in an emergency situation, i.e. fire evacuation and do reach the sidewalk downstairs for egress to outside the building. An independent company, RTM, completed an FSES review in 2021 and determined all the Interstitial spaces of the basement levels and 2nd floor will require the installation of smoke and heat detectors. Once the smoke detection system is installed, it will give these zones a passing FSES score, including the stairwell. Installation has been delayed by plan review and SafeCare obtaining the necessary equipment to complete the smoke detection system.* *Based on FSES scoring,*	02/15/2023

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			additional work will need to be done to upgrade the smoke detection system. Total Coverage smoke detection includes the installation of automatic smoke detection in all rooms, halls, storage areas, basements, attics, lofts, spaces above suspended ceilings, and other subdivisions and accessible spaces as well as the inside of all closets, elevator shafts, enclosed stairways, dumb waiter shafts and chutes (NFPA 72-2010 Section 17.5.3.1). *The facility hired the company, SafeCare, to designate areas requiring additional smoke detection coverage. They will also upgrade the Fire Alarm System. SafeCare will submit the necessary paperwork to the Indiana State Department of Health and Homeland Security for the design release. There are no changes to NFPA 99 or the facility's essential electrical system. Based on information from the engineer, plan review will not be necessary per Amy Kelley at Indiana State Department of Health (emails attached). SafeCare will install/replace the following items: a new fire panel, additional smoke and heat detectors, carbon monoxide detectors, strobes, pull stations and relay modules with a completion date of December 5,*	

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			2022. Once the install has been completed Life safety will be notified to give certification of completed engineer plans. *A new FSES survey was conducted on 6/29/22 by RTM, completed paperwork included.* *SafeCare has attempted to order the necessary parts to complete the project but the parts are backordered. Colonial is attempting to get a list of the needed parts from SafeCare to see if the needed parts can be obtained from a different vendor. We have also contacted Koorsen Fire Co. to see if they would be able to complete the project sooner, which they could not (response included). No definite start date can be given at this time. They estimated time to complete the project is 3-4 weeks. The project is estimated to start in October of 2022 pending the availability of parts. The facility is committed to the installation of the Complete Smoke Detection System described above to be performed by SafeCare. This will give the building a passing score in the FSES.* Milestones Colonial nursing representative/designee will communicate with vendor Safe Care at minimum 2 times per month for updates and	

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			developments r/t pending project. Colonial Nursing representative/designee will report update of status to ISDH of pending project monthly by the 15th of each month and with each new development until project is complete. Reporting will be in writing by email and reference Survey ID. ISDH will be notified in writing by email when parts are received by Vendor to complete project. Notified when project begins and when project is complete. *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?* *Potentially 6 residents on the upper floor could be affected. The above remedies cover all potential stairways and smokeproof enclosures.* *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 will be educated on the proper FSES paperwork for the Life Safety binder.* *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?* *Proper FSES paperwork will be reviewed in QAPI meeting on at*	

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			least a quarterly basis. *By what date the systemic changes will be completed?* 2/15/23	
K 0225 SS=E Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Based on observation and interview, the facility failed to provide and maintain exit stairs and exit stair enclosures in accordance with NFPA 101 - 2012 edition, Sections 19.2, 19.2.1, 19.2.2.3, 7.1.3.2, 7.1.3.2.1, 7.1.3.2.3, 7.1.10, 7.1.10.1, 7.2.2, 7.2.2.1, 7.2.2.1.1, 7.2.2.3.3, 7.2.2.3.3.1, 7.2.2.3.3.4, 7.2.2.2, 7.2.2.2.1, 7.2.2.2.1.1, 7.2.2.5.3, 7.2.2.5.3.1, 7.2.2.5.3.2, 7.7.3, 7.7.3.4, 7.2.2.3.6, 7.2.2.3.6.1, 7.2.2.3.6.2, 8.2 and Table 7.2.2.2.1.1 (b). This deficient practice could affect approximately 6 of the 35 residents. Findings include: Based on observations with the Interim Administrator and Maintenance Director on 09/07/22 during a tour of the facility from 9:30 a.m. to 10:00 a.m., the following was discovered: a) the exit stair by room 201 was not enclosed in fire rated construction. The door to the stair did not have fire resistance rating. b) the stair by room 201 consisted of metal open grate walking surfaces. The landing and all of the stair treads were metal open grate where there was 1/4-inch piece of metal and a 1-inch gap between the 1/4-inch metal pieces. This building is a healthcare occupancy. c) the stair by room 201 continued down from the upper landing 24 risers to the bottom of the stair without an intermittent landing. The	K 0225	**K225 Stairways and Smokeproof Enclosures** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** ***Requesting compliance with alleged deficiency through the Life Safety Equivalency granted through the FSES once all required work in the FSES is complete and a passing score is achieved. These stairs would only be used in an emergency situation, i.e. fire evacuation and do reach the sidewalk downstairs for egress to outside the building.*** ***An independent company, RTM, completed an FSES review in 2021 and determined all the Interstitial spaces of the basement levels and 2nd floor will require the installation of smoke and heat detectors. Once the smoke detection system is***	02/15/2023

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	approximately 15-foot distance exceeded the allowable maximum 12-foot distance between landings. d) the stair by room 201 only had a 30-inch clear width and not the required minimum 36-inch clear width. Based on record review of the facility's plan of correction, the facility planned to upgrade the fire alarm system prior to 09/05/22 in order to achieve a passing score on the FSES conducted on 06/29/22. Based on an interview with the Interim Administrator at the time of interview, the facility had not completed the fire alarm system upgrades. This finding was reviewed with the Interim Administrator at the exit conference at 11.50 a.m. This deficiency was cited on 06/06/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		***installed, it will give these zones a passing FSES score, including the stairwell. Installation has been delayed by plan review and SafeCare obtaining the necessary equipment to complete the smoke detection system.*** ***Based on FSES scoring, additional work will need to be done to upgrade the smoke detection system. Total Coverage smoke detection includes the installation of automatic*** ***smoke detection in all rooms, halls, storage areas, basements, attics, lofts, spaces above suspended ceilings, and other subdivisions and accessible spaces as well as the inside of all closets, elevator shafts, enclosed stairways, dumb waiter shafts and chutes (NFPA 72-2010 Section 17.5.3.1).*** ***The facility hired the company, SafeCare, to designate areas requiring additional smoke detection coverage. They will also upgrade the Fire Alarm System. SafeCare will submit the necessary paperwork to the Indiana State Department of Health and Homeland Security for the design release. There are***	

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			no changes to NFPA 99 or the facility's essential electrical system. Based on information from the engineer, plan review will not be necessary per Amy Kelley at Indiana State Department of Health (emails attached). SafeCare will install/replace the following items: a new fire panel, additional smoke and heat detectors, carbon monoxide detectors, strobes, pull stations and relay modules with a completion date of December 5, 2022. Once the install has been completed Life safety will be notified to give certification of completed engineer plans. ***A new FSES survey was conducted on 6/29/22 by RTM, completed paperwork included.*** ***SafeCare has attempted to order the necessary parts to complete the project but the parts are backordered. Colonial is attempting to get a list of the needed parts from SafeCare to see if the needed parts can be obtained from a different vendor. We have also contacted Koorsen Fire Co. to see if they would be able to complete the project sooner, which they***	

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			could not (response included). No definite start date can be given at this time. They estimated time to complete the project is 3-4 weeks. ***The project is estimated to start in October of 2022 pending the availability of parts. The facility is committed to the installation of the Complete Smoke Detection System described above to be performed by SafeCare. This will give the building a passing score in the FSES.*** **Milestones** **Colonial nursing representative/designee will communicate with vendor Safe Care at minimum 2 times per month for updates and developments r/t pending project.** **Colonial Nursing representative/designee will report update of status to ISDH of pending project monthly by the 15th of each month and with each new development until project is complete. Reporting will be in writing by email and reference Survey ID.** **ISDH will be notified in writing by email when parts are received by Vendor to**	

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			complete project. Notified when project begins and when project is complete. ***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?*** ***Potentially 6 residents on the upper floor could be affected. The above remedies cover all potential stairways and smokeproof enclosures.*** ***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 will be educated on the proper FSES paperwork for the Life Safety binder.*** ***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?*** ***Proper FSES paperwork will be reviewed in QAPI meeting on at least a quarterly basis.*** ***By what date the systemic changes will be completed?***	

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			2/15/23	
K 0353 SS=E 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 Based on record review and interview, the facility failed to ensure the ceiling construction throughout the facility was maintained as indicated in the plan of correction. This deficient practice could affect at least 6 residents and staff in therapy. Findings include: Based on interview and record review with the Interim Administrator and the Maintenance Director at 12:14 p.m. on 09/07/22, the facility was unable to provide documentation of a facility wide	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?* *The residents and staff in the identified area were not harmed by the alleged deficient practice. The 2 areas identified by the surveyor were patched by the Director of Maintenance using 5/8 drywall to give the area 1 hour protection and*	10/07/2022

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	audit of the sprinkler heads and the ceiling surrounding them as indicated in the plan of correction. This finding was reviewed with the Interim Administrator and the Maintenance Director at the exit conference at 12.25 p.m. This deficiency was cited on 06/06/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		*create a smooth continuous ceiling.* *This has been visualized by ISDH and CMS life safety surveyor on 9/7/22* *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?* No other residents were affected by the alleged deficient practice. A facility wide audit of sprinkler heads and the ceiling surrounding them was completed by the Maintenance Director to ensure that there was a smooth, continuous ceiling. No other areas were found. *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur?* An in-service was done with the Director of Maintenance on the proper ceiling space around a sprinkler head. An audit tool was created to monitor the ceiling surrounding sprinklers. Contracted vendor completed a facility wide audit on 9/27/22 and reviewed findings with maintenance director and administrator. Sprinkler heads were cleaned and serviced 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*	

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			put into place? The Director of Maintenance or Designee will conduct an audit of 5 random sprinkler heads in the building to ensure that the surrounding ceiling meets NFPA guidelines of a smooth continuous surface. The audit will be conducted weekly times 4 then monthly times five. This audit has been added to the TELS system for ongoing monitoring. The facility will conduct and document monthly audits of sprinkler heads and the ceiling around the sprinkler heads to ensure the sprinkler system operates as designed and sprinkler response time is not inhibited by holes or gaps. Ongoing, the administrator or designee will monitor the ceiling/sprinkler system to ensure continued compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing. *By what date the systemic changes will be completed?* **10/7/22**	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in			

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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
	accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on interview and record review, the facility failed to ensure portable fire extinguishers were properly maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. This deficient practice could affect 6 residents and staff on the second floor . Findings include: Based on interview and record review of the "2022 Life Safety Audits" with the Interim Administrator and the Maintenance Director at 12:14 p.m. on 09/07/22, the facility was unable to provide a monthly audit for August to ensure the compliance of five fire extinguishers in the building as indicated in the plan of correction. This finding was reviewed with the Interim Administrator and the Maintenance Director at the exit conference at 12.25 p.m. This deficiency was cited on 06/06/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)	K 0355	**K355 Portable Fire Extinguishers** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* *The residents and staff in the identified area were not harmed by the alleged deficient practice. The fire extinguisher in the wall recess was attached to the wall using a mounting bracket.* *This has been visualized by ISDH and CMS life safety surveyor on 9/7/22 and state fire marshal on 9/13/22 with no deficit findings.* *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?* No other residents were affected by the alleged deficient practice. A facility wide audit of fire extinguishers was completed by the Maintenance Director to ensure that all were properly stored according to NFPA guidelines. No unsecure fire extinguishers were found. *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur?* An in-service was done with the Director of Maintenance on the proper securing of fire	10/07/2022

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			extinguishers according to NFPA guidelines. An audit tool will be created to ensure that the fire extinguishers are properly secured according to NFPA guidelines. *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 facility will conduct and document monthly audits of fire extinguishers to ensure the fire extinguishers operate as designed and immediately available for use. Ongoing, the administrator or designee will monitor portable fire extinguishers to ensure continued compliance. Results of the review will be reviewed during the facility Quality Assurance meeting; monitoring will be ongoing. The audit tool will be completed by the Director of Maintenance or designee weekly times four then monthly times five to ensure that 5 random fire extinguishers in the building are being properly stored. This information will be reviewed in the QA meeting. This audit has also been added to the TELS system. *By what date the systemic changes will be completed?* **10/7/22**	
K 0363 SS=E	NFPA 101 Corridor - Doors			

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Bldg. 01	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 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			

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	devices, etc. Based on observation and interview, the facility failed to ensure 3 of over 5 corridor doors in the basement had no impediment to closing and latching into the door frame. This deficient practice could affect 6 residents in the Therapy room. Findings include: Based on observations with the Interim Administrator and the Maintenance Director on 09/07/22 from 12:16 p.m. to 12:20 p.m., the following corridor doors in the basement were propped open with a wedge: 1. the Therapy Room 2. the Administrator office 3. The Social Services/Admissions/Activities/Maintenance Director's office Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned corridor doors were propped open and stated he wasn't aware the doors were not allowed to be propped open. This finding was acknowledged by the Interim Administrator and the Maintenance Director at the exit conference at 12:25 p.m. 3.1-19(b)	K 0363	**K363 Corridor-Doors** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* *The residents and staff in the identified area were not harmed by the alleged deficient practice. The areas identified by the surveyor, therapy room, social service and administrator office were immediately corrected, and doors were closed.* *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?* No other residents were affected by the alleged deficient practice. All residents have the potential to be affected. An audit of corridor doors was complete and any impediment to door closure was 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 in-service was done with the Director of Maintenance on door closures and proper maintenance to prevent impediment to corridor door closure. Doors were inspected for proper functioning and staff were educated to utilize and monitor proper door closure and not prop doors open with any device.	10/07/2022

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			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 or Designee will conduct an audit of 3 random corridor doors in the building to ensure that doors are closed or opened properly. The audit will be conducted weekly times 4 then monthly times five. This information will be reviewed in the QA meeting at least quarterly. *By what date the systemic changes will be completed?* **10/7/2022**	
K 0522 SS=D Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on interview and record review, the facility failed to ensure 1 of 1 laundry rooms maintained the intake combustion air from the outside for the fuel fired dryers. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for all staff	K 0522	**K522 HVAC- Any Heating Device** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*	10/07/2022

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	in the laundry room. Findings include: Based on interview and record review of the "2022 Life Safety Audits" with the Interim Administrator and the Maintenance Director at 12:14 p.m. on 09/07/22, the facility was unable to provide a monthly audit for August to ensure the compliance of the intake combustion air for the fuel fired dryers as indicated in the plan of correction. This finding was reviewed with the Interim Administrator and the Maintenance Director at the exit conference at 12.25 p.m. This deficiency was cited on 06/06/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		*No residents were identified as being harmed by the alleged deficient practice. The piece of cardboard was immediately removed while the surveyor was present allowing fresh air intake into the dryer room from outside. This has been visualized by the ISDH and CMS life safety surveyor on 9/7/22* *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?* No other residents were affected by the alleged deficient practice. This is the only laundry area in the facility. No other areas in the building required checking. *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur?* An in-service was done with the Director of Maintenance and laundry staff on the proper ventilation and dangers of blocking air intakes. An audit tool was created to ensure that this area is monitored and not obstructed preventing fresh air intake. *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 facility will conduct and document monthly audits of fresh air intakes in the laundry room	

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			with gas-fired dryers to ensure intakes remain clear. Ongoing, the administrator or designee will monitor these areas to ensure air for combustion is taken from outside to ensure continued compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing and this task has been added to the TELS system The audit tool will be completed by the Director of Maintenance or designee weekly times four then monthly times five to ensure that the air intake in the laundry area is not obstructed allowing for proper air intake. This information will be reviewed in the QA meeting at least quarterly. *By what date the systemic changes will be completed?* **10/7/2022**	
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			

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	audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure 1 of 1 August fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on record review of titled "Fire Drill Report" with the Interim Administrator and the Maintenance Director on 09/07/22 at 10:59 a.m., the fire drill conducted on 08/31/22 didn't include transmission of the fire alarm signal. Based on interview at the time of record review, the Maintenance Director confirmed that the transmission of alarm did not occur on the aforementioned fire drills. This finding was reviewed with the Administrator and Maintenance Director at the exit conference at 12.25 p.m. This deficiency was cited on 06/06/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b) 3.1-51(c)	K 0712	**K712 Fire Drills** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* *All residents could potentially be harmed by the alleged deficient practice. A fire drill will be conducted during the day shift on 6/24/22. All proper steps will be followed and the monitoring company will notified of the drill. Complete* *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 could potentially be affected by the alleged deficient practice. An audit of the drill conducted on 6/24/22 will done to ensure that proper protocol was followed and the monitoring company was notified. complete *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur?* An in-service was done with the Director of Maintenance on the proper fire drill and notification procedures. An audit tool was created to ensure that all fire drills are conducted properly. This tool is also added to TELS for continued monitoring. Additional education was provided to	10/07/2022

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			Maintenance director to ensure fire drills are pushed to service for proper notification on all shifts at required intervals. *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 facility will conduct and document monthly audits of the fire drills to ensure drills include documentation of the transmission of the alarm signal. Ongoing, the administrator or designee will monitor fire drills to ensure the documentation is complete. Results of the monitoring will be reviewed during the facility Quality Assurance meeting; monitoring ongoing and has been added to the TELS system The audit tool will be completed by the Director of Maintenance or designee monthly times six to ensure that all fire drills that month were properly conducted, and the monitoring company was notified. If there are any errors identified another drill will be conducted to ensure proper procedures are followed. This information will be reviewed in the QA meeting at least quarterly. *By what date the systemic changes will be completed?* **10/7/22**	