STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155762	A. BUILDING -- B. WING	10/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FOREST PARK HEALTH CAMPUS	2401 SOUTH L ST RICHMOND, IN 47374

(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: 10/04/22 Facility Number: 011387 Provider Number: 155762 AIM Number: 200853180 At this Emergency Preparedness survey, Forest Park Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 70 certified beds. At the time of the survey the census was 51. Quality Review completed on 10/07/22	E 0000		
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: 10/04/22 Facility Number: 011387 Provider Number: 155762 AIM Number: 200853180 At this Life Safety Code survey, Forest Park Health Campus was found not in compliance with	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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	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 was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, all areas open to the corridor and hard wired detectors in all resident sleeping rooms. The facility has a capacity of 70 and had a census of 51 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 10/07/22			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.			

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	18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted			

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	on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	1. Based on observation and interview, the facility failed to ensure all doors were provided with only one latching mechanism to release the door and open. 33.2.2.5.7 refers to 7.2.1.5.10 which states a latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions. 7.2.1.5.10.4 states the releasing mechanism shall open the door leaf with not more than one releasing operation. 7.2.1.5.10.1 states the releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches, above the finished floor. This deficient practice could affect 4 occupants. Findings include: Based on observations and interview during a facility tour with the Director of Plant Operations, Sr. Director of Plant Operations and Facility Management Support personnel on 10/04/22 between1:15 p.m. and 2:45 p.m., the Business Office was equipped with two latching devices, a regular door handle with a latching mechanism and a separate keyed dead bolt type locking latch. The Sr. Director of Plant Operations agreed that, when locked, to exit the Business Office it would require two separate actions to open the door. This finding was acknowledged by the Director of Plant Operations, Executive Director, Sr. Director of Plant Operations and Facility Management Support personnel at the time of observation and	K 0222	**K222** **Egress Doors** **Immediate Intervention** Secondary bolt action lock was removed, and area covered by approved cover in the business office. Egress signage that was faded has been replaced with new visible signage **Exhibit A- Photo** **Exhibit B - Photo** **Compliance Date** **10-12-22** The Director of plant operations was educated by regional support on egress doors NFPA101 stating that doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key. This is in accordance with 7.2.1.5.10.4. the director was also educated on egress signage as it pertains to location and visibility requirements as stated in LSC 7.2.1.6.1 **Exhibit C – Inservice Documentation** The Director of plant operations will complete a visual inspection on the building for locking devices once a week x3 months then monthly x 3 months. The director of plant operation will	10/12/2022

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	again at the exit conference with at 3:45 p.m. with the Director of Plant Operations, Executive Director, and Facility Management Support personnel present. 2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 12 delayed egress locks was readily accessible for all residents, staff, and visitors. LSC 7.2.1.6.1.(3)(4) states a readily visible, durable sign in letters not less than 1 in. (25mm) high and not less than 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect 23 residents. Findings include: Based on observations and interview during a facility tour with the Director of Plant Operations, Sr. Director of Plant Operations and Facility Management Support personnel on 10/04/22 between1:15 p.m. and 2:45 p.m., the delayed egress signage on the service exit door behind the laundry was faded out and the words were no longer readable. The door was provided with delayed egress locks but lacked the proper signage indicating the doors can be opened in 15 seconds by pushing on the door. Based on interview at the time of observation, the Sr. Director of Plant Operations acknowledged the door was equipped with a delayed egress and lacked readable signage. This finding was acknowledged by the Director of Plant Operations, Executive Director, Sr. Director of Plant Operations and Facility Management		complete a visual inspection on egress signage one a week x 3 months then monthly x 3 months **Exhibit D – Audit tool** **Exhibit E – Audit tool** Executive Director will present results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	

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	Support personnel at the time of observation and again at the exit conference with at 3:45 p.m. with the Director of Plant Operations, Executive Director, and Facility Management Support personnel present. 3.1-19(b)			
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7			
	Based on observation and interview, the facility failed to ensure 2 of 8 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect 25 residents and staff using the 300 Hall and East Laundry Exit. Findings include: Based on observations and interview during a facility tour with the Director of Plant Operations, Sr. Director of Plant Operations and Facility Management Support personnel on 10/04/22 between1:15 p.m. and 2:45 p.m., the exit discharge from the 300 Hall and the Laundry East Exit, was a concrete sidewalk which terminated at the parking lot. At the point of termination there was a 7 inch drop into the parking lot area. Based on interview at the time of observation, the Sr. Director of Plant	K 0271	**K271** **Discharge from exits** **Immediate intervention** Contractor has been contacted to quote the removal of the 7 inch drop at the point of termination **Compliance date** **11-4-22** The Director of plant operations was educated by Regional Support on NFPA 101 as regards to discharge of exits and providing a hard packed all – weather travel surface in accordance with 7.7, 7.1.7, 18.2.7, 19.2.7 **Exhibit C – Inservice Documentation** The director of plant operations will visually inspect exit discharge monthly x 6 **Exhibit F - Audit tool**	11/04/2022

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	Operations acknowledged the condition stating that a ramp of some sort would be needed and that they had this issue at a sister facility which is of the same building design. This finding was acknowledged by the Director of Plant Operations, Executive Director, Sr. Director of Plant Operations and Facility Management Support personnel at the time of observation and again at the exit conference with at 3:45 p.m. with the Director of Plant Operations, Executive Director, and Facility Management Support personnel present. 3.1-19(b)		Executive Director will present results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A			

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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 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 5 residents, as well as staff and visitors. Findings include: Based on observations and interview during a facility tour with the Director of Plant Operations, Sr. Director of Plant Operations and Facility Management Support personnel on 10/04/22 between1:15 p.m. and 2:45 p.m., the environmental services office, greater than 50 square feet contained a number of combustible items, such as toilet paper, plastic, cleaning chemicals and cardboard boxes. The corridor door to this room was not provided with a self-closing device. This finding was acknowledged by the Director of Plant Operations, Executive Director, Sr. Director of Plant Operations and Facility Management Support personnel at the time of observation and again at the exit conference with at 3:45 p.m. with the Director of Plant Operations, Executive Director, and Facility Management Support personnel present.	K 0321	**K321** **Hazardous Areas - Enclosure** **Immediate intervention** Installed approved door closer for the environmental services offices and verified its operation **Exhibit G – Photo** **Compliance date** **11-4-22** The director of plant operations was educated by regional support on NFPA 101- hazardous areas as regards to the corridor door to this room requiring a self-closing device in accordance to 8.7.1 or 19.3.5.9, 19.3.2.1 **Exhibit C – Inservice Documentation** The director of plant operations will visually inspect all doors that exit unto common corridor weekly x 3 months then monthly x3. **Exhibit H – Audit tool** Executive Director will present results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial	11/04/2022

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	3.1-19(b)		compliance has been achieved.	
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 observation and interview, the facility failed to ensure 1 of 1 sprinkler heads in the walk-in cooler was not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect 6 kitchen staff.	K 0353	**K353** **Sprinkler System – Maintenance and testing** **Immediate intervention** Foreign material was removed from one sprinkler head as noted **Exhibit I – photo** **Compliance date** **10-12-22** Director of plant operations was educated by Regional Support on K353 NFPA 101 Sprinkler System- Maintenance and testing. Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with	10/12/2022

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	Findings include: Based on observations and interview during a facility tour with the Director of Plant Operations, Sr. Director of Plant Operations and Facility Management Support personnel on 10/04/22 between1:15 p.m. and 2:45 p.m., 1 of 1 sprinkler heads in the walk-in cooler was coved in dust or showed signs of loading. This finding was acknowledged by the Director of Plant Operations, Executive Director, Sr. Director of Plant Operations and Facility Management Support personnel at the time of observation and again at the exit conference with at 3:45 p.m. with the Director of Plant Operations, Executive Director, and Facility Management Support personnel present. 3.1-19(b)		NFPA25, Standard of 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. **Exhibit C – Inservice Documentation** Director of plant operations will visually inspection all Sprinkler Heads once weekly X3 months. Followed by once month X3 **Exhibit J – Audit tool** Executive Director will present results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
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			

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	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 devices, etc.			
	1. Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors would resist the passage of smoke. This deficient practice could affect 4 residents. Findings include: Based on observations and interview during a facility tour with the Director of Plant Operations, Sr. Director of Plant Operations and Facility	K 0363	**K363 Corridor Doors** **Immediate Intervention**: Director of plant operations has corrected the penetrations in the door and closing and latching to meet deficiency K363 **Exhibit K – Photo** **Exhibit L - Photo** **Compliance date**	10/22/2022

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	Management Support personnel on 10/04/22 between1:15 p.m. and 2:45 p.m., the "Assisted Feed" corridor door had 4 holes which penetrated completely through the door near the handle. The Sr. Director of Plant Operations stated that either caulk or a wider backing plate would need to be installed. This finding was acknowledged by the Director of Plant Operations, Executive Director, Sr. Director of Plant Operations and Facility Management Support personnel at the time of observation and again at the exit conference with at 3:45 p.m. with the Director of Plant Operations, Executive Director, and Facility Management Support personnel present. 2. Based on observation and interview, the facility failed to ensure 2 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 6 staff. Findings include: Based on observations and interview during a facility tour with the Director of Plant Operations, Sr. Director of Plant Operations and Facility Management Support personnel on 10/04/22 between1:15 p.m. and 2:45 p.m., the (1) service hall entrance door into the health center, and (2) the corridor door to the Spa, each equipped with a self closing device, failed to close and latch positively into the door frame. Based on interview at the time of the observations, the Sr. Director of Plant Operations agreed the aforementioned corridor doors did not close and latch into the door frame and would not resist the passage of smoke. This finding was acknowledged by the Director of		10-22-22 Director of Plant Operations was educated by regional support on K363 NFPA 101 corridor and doors. Corridor doors and doors to rooms that would resist the passage of smoke must have latching hardware. **Exhibit C – Inservice Documentation** Director of plant operations will verify positive latching hardware to doors protecting corridor openings. Once per weekly X 3months Followed by Once per Month X3 **Exhibit M – Audit tool** Executive Director will present results of inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FOREST PARK HEALTH CAMPUS	2401 SOUTH L ST RICHMOND, IN 47374

(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
	Plant Operations, Executive Director, Sr. Director of Plant Operations and Facility Management Support personnel at the time of observation and again at the exit conference with at 3:45 p.m. with the Director of Plant Operations, Executive Director, and Facility Management Support personnel present. 3.1-19(b)			
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9			
	Based on observation and interview, the facility failed to ensure 1 of 5 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect 20 residents. Findings include:	K 0374	**K374** **Subdivision of Building Spaces – Smoke barriers** **Immediate intervention** The Director of plant operations adjusted the door hinge assembly as to allow the smoke door to close completely and latch to meet deficiency K473. **Exhibit N – photo** **Compliance date** **10-14-22**	10/14/2022

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	Based on observations and interview during a facility tour with the Director of Plant Operations, Sr. Director of Plant Operations and Facility Management Support personnel on 10/04/22 between1:15 p.m. and 2:45 p.m., the set of smoke barrier doors near the conference room into the dining room in the health center did not close completely and latch. One of the two doors was rubbing near the bottom on the carpet and would catch and not close completely. Based on interview during the time of observations, the Sr. Director of Plant Operations acknowledged these smoke barrier doors did not close completely and latch. This finding was acknowledged by the Director of Plant Operations, Executive Director, Sr. Director of Plant Operations and Facility Management Support personnel at the time of observation and again at the exit conference with at 3:45 p.m. with the Director of Plant Operations, Executive Director, and Facility Management Support personnel present. 3.1-19(b)		The director of plant operations was educated by the regional support on K374 NFPA 101 as pertains to operation of smoke barrier doors and requirements in accordance with LSC 19.3.7.8, section 8.5.4. LSC 8.5.4.1 **Exhibit C – Inservice Documentation** The director of plant operations will visually inspect operation of smoke barrier doors weekly x 3 months then monthly x3 **Exhibit O – audit tool** Executive Director will present results of inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
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 ensure 1 of 1 flexible cords was not used as a substitute for fixed wiring according to 33.2.5.1. LSC 33.2.5.1 states utilities shall comply	K 0511	**K511** **Utilities – Gas and electric** **Immediate intervention** The director of plant operations	10/04/2022

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	with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 4 occupants in the Salon. Findings include: Based on observations and interview during a facility tour with the Director of Plant Operations, Sr. Director of Plant Operations and Facility Management Support personnel on 10/04/22 between1:15 p.m. and 2:45 p.m., in the Salon what appeared to this surveyor to be an extension cord with several adaptors on one end was positioned to plug into a wall outlet. The Sr. Director of Plant Operations agreed that it appeared the aforementioned extension cord was used in the Salon and he removed the extension cord during the survey. This finding was acknowledged by the Director of Plant Operations, Executive Director, Sr. Director of Plant Operations and Facility Management Support personnel at the time of observation and again at the exit conference with at 3:45 p.m. with the Director of Plant Operations, Executive Director, and Facility Management Support personnel present. 3.1-19(b)		removed multi plug extension cord from the beauty shop to meet deficiency K511 **Compliance date 10-4-22** Director of plant Operations was educated by the regional support on K511 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. **Exhibit C – Inservice Documentation** Director of plant Operations will verify no unapproved cords weekly X3months then followed monthly X3. **Exhibit P – Audit tool** Executive Director will present results of inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in			

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	accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation and interview; the facility failed to ensure fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on records review and interview with the Director of Plant Operations, Executive Director, Sr. Director of Plant Operations and Facility Management Support personnel on 10/04/22	K 0521	**K521** **HVAC** **Immediate intervention** Unable to obtain paperwork showing corrected items have contacted another vendor to inspect fire dampers to meet deficiency K521 **Compliance date** **11-4-22** The director of plant operations was educated by regional support on NFPA 90A , LSC9.2.1, NFPA 80, 19.4.1.1 as pertains to maintenance and testing of fire dampers and documentation of location, date of inspection, name of inspector, and deficiencies discovered. **Exhibit C – Inservice Documentation** The director of plant operations will maintain documentation of completion and will provide new documentation as per regulation states. Executive Director will present results of inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	11/04/2022

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	between 10:45 a.m. and 1:15 p.m., the fire damper inspection of the facilities fire and smoke dampers dated 06/16/19 stated repairs were needed as some dampers when tested failed to close. No documentation was provided confirming the needed repairs/replacements had been made. The Sr. Director of Plant Operations stated he was unaware of the issues and sought more information from the facilities contractor who performed the inspections, but no additional documentation was made available during the survey. This finding was acknowledged by the Director of Plant Operations, Executive Director, Sr. Director of Plant Operations and Facility Management Support personnel at the time of observation and again at the exit conference with at 3:45 p.m. with the Director of Plant Operations, Executive Director, and Facility Management Support personnel present. 3.1-19(b)			
K 0712 SS=C 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	K 0712	**K712**	10/14/2022

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	failed to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on records review of the " Fire Drill Report" and interview with the Director of Plant Operations, Executive Director, Sr. Director of Plant Operations and Facility Management Support personnel on 10/04/22 between 10:45 a.m. and 1:15 p.m., 11 of 12 fire drills were conducted near the end of the month, between the 26th and 31st day of the month. These conditions do not allow fire drills to be conducted at unexpected times. This finding was acknowledged by the Director of Plant Operations, Executive Director, Sr. Director of Plant Operations and Facility Management Support personnel at the time of observation and again at the exit conference with at 3:45 p.m. with the Director of Plant Operations, Executive Director, and Facility Management Support personnel present. 3.1-19(b)		**Fire Drill** **Immediate Intervention** As noted during survey findings the fire drills were scheduled to close to the end of the month going forward all drills will be performed in various times and dates **Compliance Date** **10-14-22** The director of plant operations was educated by regional support on the requirements of NFPA 101 concerning fire drills are to be held at various times and dates to ensure conditions of drills being conducted on unexpected days and unpredictable times under varying conditions, at least quarterly on each shift. **Exhibit C – Inservice Documentation** The Executive director and the Director of plant operations will present information x 12 months to the QAPI committee for further recommendation and will continue until the QAPI team determines substantial compliance has been achieved.	

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K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure 1 of 1 power cord daisy chains were not used as and as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. Article 400.8 (1) prohibits daisy	K 0920	**K920** **Electrical Equipment – Power cords and extension cords** **Immediate intervention** The power strip located in the medical records office was removed and placed directly into	10/14/2022

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	chains, because the first extension cord (or power strip) is now acting as a substitute for the fixed wiring of a structure. This deficient practice could affect up to 3 staff. Findings include: Based on observations and interview during a facility tour with the Director of Plant Operations, Sr. Director of Plant Operations and Facility Management Support personnel on 10/04/22 between1:15 p.m. and 2:45 p.m., in the Medical Records Office a power strip was plugged into and supplied power to another power strip. Based on interview at the time of observation, the Sr. Director of Plant Operations agreed a power strips were daisy chained together. This finding was acknowledged by the Director of Plant Operations, Executive Director, Sr. Director of Plant Operations and Facility Management Support personnel at the time of observation and again at the exit conference with at 3:45 p.m. with the Director of Plant Operations, Executive Director, and Facility Management Support personnel present. 2. Based on observation and interview, the facility failed to ensure 1 of 1 resident rooms did not used multi-plug adaptors as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects 2 residents. Findings include:		an outlet eliminating the “daisy chain effect”. The multi tap outlet was removed from the resident room **Exhibit Q – Photo** **Exhibit R – Photo** **Compliance date 10-14-22** The Director of plant operations was educated by regional support on K920 NFPA 101 10.2.3.6, NFPA 70/2011, 400.8, 400.7. as pertains to flexible cords and cables should not be used as a substitute for fixed wiring and prohibiting daisy chains. **Exhibit C – Inservice Documentation** The director of plant operations and the Executive director will verify non approved devices are not in use once per week x 3 months followed by once per month x 3. **Exhibit S – Audit tool** Executive Director will present results of inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	

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	Based on observations and interview during a facility tour with the Director of Plant Operations, Sr. Director of Plant Operations and Facility Management Support personnel on 10/04/22 between1:15 p.m. and 2:45 p.m., Resident Room 205 contained a multi-plug adaptor powering electronic equipment. This finding was acknowledged by the Director of Plant Operations, Executive Director, Sr. Director of Plant Operations and Facility Management Support personnel at the time of observation and again at the exit conference with at 3:45 p.m. with the Director of Plant Operations, Executive Director, and Facility Management Support personnel present. 3.1-19(b)			