STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING -- B. WING	01/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF SCOTTSBURG, THE	1350 N TODD DR SCOTTSBURG, IN 47170

(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: 01/23/23 Facility Number: 000478 Provider Number: 155494 AIM Number: 100290430 At this Emergency Preparedness survey, The Waters of Scottsburg was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 99 certified beds. At the time of the survey, the census was 63. Quality Review completed on 01/30/23	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: 01/23/23 Facility Number: 000478 Provider Number: 155494 AIM Number: 100290430 At this Life Safety Code survey, The Waters of Scottsburg was found not in compliance with	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melinda Hewitt	Administrator	02/17/2023

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF SCOTTSBURG, THE	1350 N TODD DR SCOTTSBURG, IN 47170

(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
	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The building was surveyed with Chapter 19 Existing Health Care Occupancies. This one story facility was determined to be of Type V (000) construction and was fully sprinkled. The facility has a fire alarm system with smoke detection in corridors and areas open to the corridor, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 99 and had a census of 63 at the time of this survey. All areas where the residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 01/30/23			
K 0200 SS=E Bldg. 01	NFPA 101 Means of Egress Requirements - Other Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2			
	Based on observation and interview, the facility failed to ensure 3 of 3 egress doors from the three rest rooms, were not equipped with a locking device that would require the use of a key to unlock from the inside in the case of fire or other emergencies in accordance with LSC 7.1.10.1.	K 0200	**K200** – It is the intent of the facility to ensure egress doors from the three rest rooms are not equipped with a locking device that would require the use of a key to unlock from the inside in the	01/31/2023

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	155494	A. BUILDING 01 B. WING	01/23/2023

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WATERS OF SCOTTSBURG, THE	1350 N TODD DR SCOTTSBURG, IN 47170

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	This deficient practice could affect three residents, staff or visitors. Findings include: Based on observations on 01/23/23 between 1:30 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Director, the two public rest rooms in the front entrance corridor, and the restroom in the Springs Hope dining room were all equipped with slide bolt locking devices on the inside of the door which would not allow entrance into any of the three bathrooms without removing the door. Based on interview at the time of observations, the Maintenance Director agreed these doors could not be unlocked from outside the door. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		case of fire or other emergencies in accordance with LSC 7.1.10.1 to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 1/24/2023 the Maintenance Supervisor/designee removed the slide bolt locking devices on the inside of the two public rest rooms in the front entrance corridor and the restroom in the Springs hope dining room to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 1/24/23 the Maintenance Supervisor/designee inspected the egress doors and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 1/25/2023 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that egress doors are not equipped with a locking device that would require the use of a key to unlock from the inside in the case of fire or other emergency to meet set standards. b. Maintenance Supervisor/designee will inspect all egress doors throughout the facility weekly to ensure they are not equipped with a locking device that would require the use of a key	

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			to unlock from the inside in the case of fire or other emergency as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 1/31/2023.**	

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K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure 1 of 11 exit means of egress was properly lighted and would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect up to 18 residents as well as staff and visitors in the Hope Springs Unit if required to exit through the Hope Springs Unit dining room exit door in the event of an emergency. Findings include: Based on observations on 01/23/23 between 1:30 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Director, the Hope Springs Unit dining room courtyard exit was not provided with exterior lighting outside the exit and to the public way. Based on interview at the time of observation, the Maintenance Director agreed there needs to be exterior lighting provided within the courtyard to the public way. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	K 0281	**K281**– It is the intent of the facility to ensure exit means of egress is properly lighted and would not leave the area in darkness to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On the Maintenance Supervisor/designee installed egress lighting to the public way at the courtyard exit to meet set standards. The Administrator verified the repairs on 1/27/2023. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 1/27/2023 the Maintenance Supervisor/designee inspected all means of egress lights throughout the facility to ensure exit lighting is working properly and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 01/27/2023 the Administrator inserviced the	01/31/2023

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	3.1-19(b)		Maintenance Supervisor/designee on the requirement that continuity of egress lighting remains for exits to meet set standards. b. Maintenance Supervisor/designee will inspect lighting in all means of egress weekly to ensure lighting is working properly as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure	

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			compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 01/31/2023.**	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 1. Based on observation and interview, the facility failed to replace battery operated smoke alarms installed in 47 of over 50 resident sleeping rooms and other areas of the facility in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations on 01/23/23 between 10:00 a.m. and 1:30 p.m. while performing record review, the Maintenance Director brought in a few resident room battery operated smoke alarms. Almost all resident room battery operated smoke alarms had manufactured dates of 2008 or 2009	K 0300	**K300**– It is the intent of the facility to ensure to replace battery operated smoke alarms installed in resident sleeping rooms and other areas of the facility in accordance with NFPA 72 and to ensure documentation for the preventative maintenance of battery-operated smoke alarms in resident rooms is complete to meet set standards. **1) CORRECTIVE ACTIONS TAKEN**: a) On 1/30/2023 the Maintenance Supervisor/designee removed all the battery-operated smoke alarms and replaced them with new battery-operated smoke alarms and new batteries and documented the installation on the battery operated smoke alarms and documented on the	01/31/2023

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	prior. Two resident room battery operated smoke alarms had manufactured dates of 2016. The smoke alarms observed all stated "replace the unit within 10 years of installation date". The Maintenance Supervisor said a few smoke alarms had been replaced prior to him becoming the Maintenance Director, but confirmed most smoke alarms had manufactured dates of 2008 and 2009 and agreed they were past due for replacement. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure documentation for the preventative maintenance of battery operated smoke alarms in 47 of 47 resident rooms, plus a few other areas, was complete. NFPA 72 14.2.1.1.1 states to ensure operations integrity, the system shall have an inspection, testing, and maintenance program. NFPA 72 29.10 states fire-warning equipment shall be maintained and tested in accordance with manufacturer's published instructions and per the requirements of Chapter 14. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 01/23/23 between 10:00 a.m. and 1:30 p.m. with the Maintenance Director present, the battery operated smoke alarm maintenance documentation failed to indicate smoke alarm and/or battery replacement. Based on interview at the time of record review, the Maintenance Director said he was not aware the batteries in the smoke alarms were required to be		Battery-Operated Smoke Detector Maintenance Log to meet set standards. The Administrator verified the installation on 01/31/2023. **2) ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a) All residents and all staff and visitors have the potential to be affected but none were. **3) MEASURES TO PREVENT REOCCURRENCE**: a) On 01/30/2023 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that battery operated smoke alarms must be maintained and documentation retained at the facility to meet set standards. b) Maintenance Supervisor/designee will conduct testing on all battery-operated smoke detectors per manufacturer's guidelines throughout the facility and document the results on the Battery-Operated Smoke Detector Maintenance Log to be filed in the Life Safety Binder as a part of the facility's Preventive Maintenance Program. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c) The Administrator will monitor adherence to the Preventative Maintenance	

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	replaced unless they were beeping. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		schedule and validate the Preventative Maintenance documentation is in place. **4) MONITORING CORRECTIVE ACTION**: a) The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 01/31/2023.**	
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			

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	automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor door to 1 of over 10 hazardous area doors, such as a shower room containing soiled linen barrels over 32 gallons, was provided with a properly working self closing door. This deficient practice could affect at least 18 residents, as well as staff, and visitors. Findings include: Based on observations on 01/23/23 between 1:30 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Director, the Morgan Unit shower room was over 50 square feet in size and contained two 50 gallon soiled linen carts. The corridor door to this shower room was provided with a self closing device, however, the bottom of the door was wedged tightly against the shower	K 0321	**K321**– It is the intent of the facility to ensure the corridor door to hazardous area doors, such as a shower room containing soiled linen barrels over 32 gallons, is provided with a properly working self-closing door to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 01/25/2023 the Maintenance Supervisor/designee repaired the corridor door to the Morgan Unit shower room to ensure it self closes fully into the frame to meet set standards. The Administrator verified the work on 01/25/2023.	01/31/2023

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	room floor keeping the door in the wide open position. Based on interview at the time of observation, the Maintenance Director agreed the shower room door needs to be adjusted to ensure the door stays closed at all times. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 01/25/2023 the Maintenance Supervisor/designee inspected all hazardous areas for self-closing doors and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 01/25/2023 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that all hazardous area doors must have self-closing doors to meet set standards. b. Maintenance Supervisor/designee will inspect all hazardous area doors throughout the facility monthly for functioning self-closing devices as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING**	

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			CORRECTIVE ACTION: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 01/31/2023.**	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments			

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	with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			
	Based on observation and interview, the facility failed to ensure the manual pull station for 1 of 1 kitchen range hood extinguishing system was visible and easily accessible. This deficient practice could affect kitchen staff, plus residents in the adjacent main dining room. Findings include: Based on observations on 01/23/23 between 1:30 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Director, the manual pull station for the range hood suppression system was not visible when observing the kitchen area. Based on interview at the time of observation, kitchen staff #1, when asked what she would do in the event of a fire under the range hood, she said she would pull the range hood pull station. She then moved a large refrigerator over about eight inches and exposed the range hood manual pull station next to the range hood extinguishing system. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0324	**K324**– It is the intent of the facility to ensure the manual pull station for kitchen range hood extinguishing system is visible and easily accessible to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On 01/24/2023 the Maintenance Supervisor/designee moved the refrigerator to ensure the manual pull station for the range hood suppression system is visible and accessible to meet set standards. The Administrator verified the work on 01/24/2023. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 01/24/2023 the Administrator inserviced the Maintenance Supervisor/designee and all other kitchen staff on the requirement that the kitchen range hood extinguishing system is visible and easily accessible to meet set standards.	01/31/2023

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			b. Maintenance Supervisor/designee will inspect the kitchen range hood pull station to ensure it is visible and easily accessible as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with**	

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			all regulatory requirements. Our date of compliance is 01/31/2023.	
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 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			

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	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 47 resident room corridor doors had no impediment to closing. This deficient practice could affect up to 30 residents, staff and visitors in the Morgan Unit. Findings include: Based on observations on 01/23/23 between 1:30 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Director, resident room 137 door could not be closed fully without adjusting the cubicle curtains and moving the bed. Based on interview at the time of the observation, the Maintenance Director agreed the cubicle curtains and bed in room 137 was keeping the door from closing fully. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of over 100 corridor doors would latch into its door frame. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations on 01/23/23 between 1:30	K 0363	**K363** – It is the intent of the facility to ensure resident room corridor doors had no impediment to closing and to ensure corridor doors would latch into its door frame to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On 01/24/2023 the Maintenance Supervisor/designee moved the bed and the cubicle curtains so the corridor door would close fully into the frame to meet set standards. The Administrator verified the work on 01/24/2023. b. On the Maintenance Supervisor/designee installed a strike plate and latching mechanism to the corridor door to the Medical Supply Room to ensure door latches fully into the frame to meet set standards. The Administrator verified the work on 1/24/2023. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee inspected all corridor doors and found no other negative findings. **3. MEASURES TO PREVENT**	01/31/2023

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	p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Director, the corridor door to the Medical Supply Room would not latch into its door frame because the strike plate and latching mechanism were missing. Based on interview at the time of observation, the Maintenance Director acknowledged the corridor door to the Medical Supply Room did not latch into its door frame when tested because the strike plate and latching mechanism were missing. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**REOCCURRENCE**: a. On 1/24/2023 the Administrator inserviced the Maintenance Supervisor/designee and all staff on the requirement that corridor doors must have no impediments to closing and ensure the doors would latch into its door frame to meet set standards. b. Maintenance Supervisor/designee will inspect all corridor doors throughout the facility monthly to ensure there are no impediments to closing and ensure the doors would latch into its door frame as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly	

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			Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 01/31/2023.**	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie 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 1 of 6 smoke barrier walls were protected to maintain the smoke resistance of the smoke barrier. LSC 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. This deficient practice	K 0372	**K372** – It is the intent of the facility to ensure smoke barrier walls are protected to maintain the smoke resistance of the smoke barrier to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**:	01/31/2023

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	could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 01/23/23 between 1:30 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Director, the smoke barrier wall between the Warrior Unit and central nurses' station area had a two inch conduit penetrating the wall with wires running through it that were not proper fire stopped. It appeared there was fire stop material outside the conduit, however, it had been pulled out at some point. Based on interview at the time of observation, the Maintenance Director said the opening through the smoke barrier wall would be filled with a proper fire stop material as soon as possible. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		a. On 01/27/2023 the Maintenance Supervisor/designee sealed the two inch conduit penetrating the wall in the smoke barrier wall between the Warrior Unit and central Nurses' station with a one hour fire resistant material to meet set standards. The Administrator verified the repairs on 01/27/2023. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 01/27/2023 the Maintenance Supervisor/designee inspected all smoke barrier walls & ceilings throughout the facility for penetrations and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 01/27/2023 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that smoke barrier walls & ceilings must be free of penetrations and voids to meet set standards. b. Maintenance Supervisor/designee will inspect all smoke barrier walls & ceilings throughout the facility monthly for penetrations and voids as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed	

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			and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 01/31/2023.**	
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			

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	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 ensure 3 of 12 fire drill reports included complete and up to date documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 01/23/23 between 10:00 a.m. and 1:30 p.m. with the Maintenance Director present, 3 of 12 fire drill reports performed during the past 12 month period did not include complete and up to date documentation for the transmission of the alarm to the monitoring company. The following was noted: a. 11/08/22, second shift fire drill report did not have a time of drill documented, furthermore, at "If silent alarm, date alarm was tested", it had a date of 11/02/22, which was six days prior to the fire drill. b. 09/07/22, third shift fire drill report with a time of 4:00 a.m. at "If silent alarm, date alarm was tested", it had a date of August 6, 2022, which was a month and a day prior to the fire drill. c. 08/18/22, second shift fire drill report with a	K 0712	**K712** – It is the intent of the facility to ensure fire drill reports included complete and up to date documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 01/26/2023 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that all fire drill reports must include complete and up to date documentation for the transmission of the alarm to the monitoring company to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. Maintenance Supervisor/designee will ensure all fire drill reports must include complete and up to date documentation for the	01/31/2023

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	time of 9:00 p.m. at "If silent alarm, date alarm was tested", it had a date of 08/17/22, which was a full day prior to the fire drill. Based on interview at the time of record review, the Maintenance Director acknowledged the transmission of alarm dates did not match with the actual fire drills. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3-1.19(b)		transmission of the alarm to the monitoring company and that documentation be retained in the facility's Red Binder as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. b. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.**	

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			Our date of compliance is 01/31/2023.	
K 0918 SS=C 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 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,			

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	NFPA 111, 700.10 (NFPA 70) 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. Findings include: Based on record review on 01/23/23 between 10:00 a.m. and 1:30 p.m. with the Maintenance Director present, 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, who said he has only been the Maintenance Director for a short time at the facility and was unaware of the requirement. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0918	**K918** – It is the intent of the facility to ensure to maintain 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 to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 01/31/2023 the Facilities licensed generator contractor conducted the three year four hour test of the emergency generator and documented the results in the facilities Life Safety Binder to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 01/31/2023 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that a three year period emergency generator test for four continuous hours is required to meet set standards. b. The Maintenance Supervisor/designee will ensure an emergency generator test for four continuous hours is conducted every three years and documented	01/31/2023

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			in the life safety binder to meet set standards. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 01/31/2023.**	
K 0920 SS=D 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			

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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
	(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			
	Based on observation and interview, the facility failed to ensure 1 of 1 flexible cord in the Medical Records Office was installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect residents' staff while in the Medical Records Office. Findings include: Based on observations on 01/23/23 between 1:30 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Director, there was a power strip	K 0920	**K920** – It is the intent of the facility to ensure flexible cord in the Medical Records Office is installed properly and used in a safe manner to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 01/24/2023 the Maintenance Supervisor/designee removed the power strip that was being used to power three devices in the Medical Records Office to meet set standards. The Administrator verified the removal on 01/24/2023. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to	01/31/2023

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	in the Medical Records Office used to power three devices. The power strip was not secured and dangling from the receptacle it was plugged into. This condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observation, the Maintenance Director agreed the power strip was dangling and not secured. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		be affected but none were. On 01/24/2023 the Maintenance Supervisor/designee inspected all rooms throughout the facility for power strips and found no other negative findings. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 01/24/2023 the Administrator inserviced the Maintenance Supervisor/designee/all staff that power strips are not to be used as a substitute for fixed wiring to meet set standards. 2.Maintenance Supervisor/designee will inspect all rooms throughout the facility monthly to ensure they do not have power strips in use as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the	

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			Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 01/31/2023.**	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet			

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	In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 7 smoke compartments. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.3 states storage for nonflammable gases with a total volume equal to or less than greater than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1 and 11.3.3.2. NFPA 99, Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect over 10 residents, staff, and visitors while in the front entrance corridor.	K 0923	**K923** – It is the intent of the facility to ensure cylinders of nonflammable gases such as oxygen are properly secured from falling in smoke compartments to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 01/30/2023 the Director of Nursing/designee secured the three E size oxygen cylinders in the oxygen storage/trans-filling room to meet set standards. The Administrator verified the work on 01/30/2023. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**:	01/31/2023

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	Findings include: Based on observations on 01/23/23 between 1:30 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Director, there were three E size oxygen cylinders on the floor in the oxygen transfilling/storage room freestanding and were not supported in a proper cylinder stand or otherwise secured from falling. One cylinder was leaning against another in this room. Based on interview at the time of the observation, the Maintenance Director acknowledged the E size oxygen cylinders freestanding on the floor and not supported in a cylinder stand or otherwise secured from falling. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		a. All residents and all staff and visitors have the potential to be affected but none were. On 01/30/2023 DON/designee checked all areas of the facility for improperly stored oxygen cylinders and containers and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 01/30/2023 the Administrator inserviced the DON/designee and all other nursing staff on the requirement that oxygen cylinders and liquid oxygen containers must be restrained and in the proper storage areas to meet set standards. b. The Director of Nursing/designee will inspect all oxygen cylinders and liquid oxygen containers throughout the facility weekly to ensure they are restrained and properly stored as a part of the facility's Oxygen Policy and Procedures Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Oxygen Policy & Procedures schedule and validate the Oxygen Policy & Procedures are in place.	

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			4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 01/31/2023.**	