DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING -- B. WING	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/02/23 Facility Number: 000007 Provider Number: 155019 AIM Number: 100275040 At this Emergency Preparedness survey, Garden Villa-Bloomington was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 224 certified beds. At the time of the survey, the census was 87. Quality Review completed on 02/06/23	E 0000	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of compliance effective February 13, 2023. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the Plan of Correction (POC) and supporting documents submitted.	
E 0023 SS=C Bldg. --	403.748(b)(5), 416.54(b)(4), 418.113(b)(3), 441.184(b)(5), 482.15(b)(5), 483.475(b)(5), 483.73(b)(5), 484.102(b)(4), 485.625(b)(5), 485.68(b)(3), 485.727(b)(3), 485.920(b)(4), 486.360(b)(2), 491.12(b)(3), 494.62(b)(4) Policies/Procedures for Medical Documentation §403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Angela Patterson	DON	02/13/2023

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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	[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system of medical documentation that preserves resident information, protects confidentiality of resident	E 0023	**E023** **Emergency Policies** **This facility does have Emergency Preparedness**	02/13/2023

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	information, and secures and maintains the availability of records in accordance with 42 CFR 483.73(b)(4). This deficient practice could affect all occupants. Findings include: Based on record review with the Director of Plant Operations, DON, and Administrator on 02/02/23 from 9:22 a.m. to 12:55 p.m., the provided Emergency Preparedness Plan (EPP) did not contain documentation to indicate the use of a system to preserve resident medical documentation during an emergency. Based on interview at the time of record review, the DON and the Administrator stated they use a computer based program for medical records, and agreed that was not referenced in the Emergency Preparedness Plan at the time of the survey. The finding was reviewed with the Director of Plant Operations, DON, Administrator at the exit conference.		**testing in place, in accordance with CFR(s): NFPA 110.** **Corrective actions taken:** The facility had policies in place related to medical records and the protection of the confidentiality of all residents. The policies were placed in the emergency preparedness binder. **Measures in place/system changes:** The Director of Maintenance or designee has placed the medical records policy in every emergency preparedness binder for each unit and at the front desk. This policy will be attached to the plan of correction. **(Attachment A).** **Monitoring of corrective actions taken:** The Quality Assurance and Process Improvement committee will review compliance of E023 emergency power (5) five months at the scheduled QI meetings. Following five (5) monthly quality assurance compliance reviews and if no concerns are noted, the committee will end the monitoring of E023. Date of Compliance February 13, 2023.	
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d),			

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	491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.			

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	*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.			
	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that is based on the emergency plan accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on record review with the Director of Plant Operations, DON and Administrator on 02/02/23	E 0036	**E036** **Emergency Policies Related to Staff training.** **This facility does have Emergency Policy and Procedures in place related to staff training and testing, in accordance with CFR(s): 483.73 (d). Corrective actions taken:** The facility has policies in place	02/13/2023

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	from 9:22 a.m. to 12:55 p.m., the provided Emergency Preparedness Plan (EPP) did not contain a training and testing program. Based on interview at the time of record review the Director of Plant Operations and DON stated the facility has a training program, but the program is not written into the EPP. The finding was reviewed with the Director of Plant Operations, DON and Administrator during the exit conference.		related to staff training and testing. The policies were placed in the emergency preparedness binder. **(Attachment A).** **Measures in place/system changes:** The Director of Maintenance or designee has placed the staff training and testing policy in every emergency preparedness binder for each unit and at the front desk. This policy will be attached to the plan of correction. **(Attachment B)** **Monitoring of corrective actions taken:** The Quality Assurance and Process Improvement committee will review compliance of E036 staff training and testing for (5) five months at the scheduled QI meetings. Following five (5) monthly quality assurance compliance reviews and if no concerns are noted, the committee will end the monitoring of E036. Date of Compliance February 13, 2023.	
E 0039 SS=C Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2),			

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	§485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed			

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

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

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

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

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

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

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

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	OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based	E 0039	**E039** **Emergency Preparedness Testing Requirements.** **This facility does have Emergency Preparedness testing in place related to tabletops CFR(s): 483.73 (d).** **Corrective actions taken:** The facility has policies in place related to community-based training and testing. The Director of Maintenance has contacted the Indiana State Police and Monroe County Fire District to conduct an onsite community training for	02/13/2023

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	full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Director of Plant of Operations, DON and Administrator on 02/02/23 from 9:22 a.m. to 12:55 p.m., no documentation of a community based annual exercise, an actual natural or man-made emergency, or an annual individual facility-based functional exercise if a community drill is not available was available for review. Based on interview at the time of records review, the DON stated a tabletop exercise was conducted on 07/14/22, but a community based annual exercise, an actual natural or man-made emergency, or an annual individual facility-based functional exercise has not been conducted within the last 12 months. This finding was reviewed with the Director of		staff. **Measures in place/system changes:** The Director of Maintenance or designee has contacted local agencies to conduct community based onsite training for staff related to emergency plan. **See Attached photograph (Attachment A)** **Monitoring of corrective actions taken:** The Quality Assurance and Process Improvement committee will review compliance of E039 staff training and testing for (5) five months at the scheduled QI meetings. Following five (5) monthly quality assurance compliance reviews and if no concerns are noted, the committee will end the monitoring of E039. Date of Compliance February 13, 2023.	

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	Plant Operations, DON and Administrator during the exit conference.			
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: 02/02/23 Facility Number: 000007 Provider Number: 155019 AIM Number: 100275040 At this Life Safety Code survey, Garden Villa-Bloomington was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story 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 and in all areas open to the corridor. The facility has battery operated smoke detectors installed in resident sleeping rooms 101 through 126, 201 through 216 and 301 through 339. The facility has smoke detectors hard wired to the fire alarm system in resident sleeping rooms on Station 4, 5, and 6. The facility has a capacity of 224 and had a census of 87 at the time of this survey. All areas where the residents have customary	K 0000	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility’s desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility’s credible evidence of compliance effective February 13, 2023. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the Plan of Correction (POC) and supporting documents submitted.	

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	access were sprinklered. All areas providing facility services were sprinklered except for two detached storage buildings. Quality Review completed on 02/06/23			
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. 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			

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	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 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 Based on observation and interview, the facility failed to ensure the means of egress through 3 of 13 exit doors were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be	K 0222	**K 222** **Egress Doors** **This facility does ensure that the means of Egress are not impeded through the exit doors. In accordance with the requirements of CFR(s): NFPA 101. Corrective actions taken:**	02/13/2023

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	permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 35 residents, staff and visitors in two halls. Findings include: Based on observation with the Director of Plant Operations on 02/02/23 from 12:55 p.m. to 3:10 p.m., the following was noted: a) exit doors on Station 4 by resident rooms 407 and 418 were marked as facility exits, were magnetically locked, and could be opened by inserting a key and turning in a lock on the wall by the exit. The Director of Plant Operations opened the exit doors with a key on his key ring. When asked how person(s) without a key could exit the two magnetically locked doors, he stated you would break the glass on the mounted metal box next to the lock and use the key hanging inside to unlock the lock. Based on observation, there was no information posted at the metal box containing the key to indicate how access the key and unlock the exit doors. Based on interview at the time of observation, the Director of Plant Operations agreed information on how to open the exit doors were not posted by the metal boxes containing the key. b) the marked facility exit at Station 3 south dining room, was magnetically locked and could be opened by inserting and turning a key in a lock on the wall. The Director of Plant Operations opened the exit door by using a key on his key ring. There was not metal box containing a key to unlock the exit door observed. Based on interview with the Director of Plant Operations, he stated the way to unlock this exit is by using a key in the lock on the wall, and confirmed there was not key available for use at the exit door. This finding was reviewed with the Director of		The facility added instructions to the 2 of 13 boxes outside the exit doors and added one new box for the other exit door in question. Photographs will be attached. **Attachment A**. **Measures in place/system changes:** The Director of Maintenance/or designee added instructions to two of thirteen exit doors that were in question and added the new box to the other exit door. **Monitoring of corrective actions taken:** The Quality Assurance and Process Improvement committee will review compliance of K 222 boxes at exit doors, at the scheduled QI meeting. If no issues the QA committee with discontinue all audits. Date of Compliance February 13, 2023	

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	Plant Operations, DON and Administrator during the exit conference. 3.1-19(b)			
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 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			
	1. Based on observation and interview, the facility failed to ensure the cook tops in 1 of 1 rooms was shut off at the switch when not in use. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all the following conditions: (1) The space containing the cooking equipment is not a sleeping room.	K 0324	**K324** **Cooking Facilities** **This facility does ensure that cook tops are secured and fryers are contained under hood extinguishing system in accordance with the requirements of CFR(s): NFPA 101.** **Corrective actions taken:** The	02/13/2023

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	(2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect all residents while in the Station 1 Dining Room. Findings include: Based on observation on 02/02/23 at 2:28 p.m. during a tour of the facility with the Director of Plant Operations, DON and Administrator, there was a cooktop stove in the Station 1 Dining Room. When checked, and not in use, the stove top appliance was not deactivated from the individual cooktop power sources. Based on interview at the time of observation, the Director of Plant Operations confirmed the cooktop stove was not deactivated when not in use. 2. Based on observation and interview, the facility failed ensure 1 of 1 kitchen hood extinguishing system provided complete coverage for equipment that produces grease-laden vapors. NFPA 96, 2011 edition, Section 10.1.2 requires cooking equipment that produces grease-laden vapors and that might be a source of ignition of grease in the hood, grease removal device, or duct shall be protected by fire-extinguishing equipment. This deficient practice could affect staff in the kitchen.		facility had a cook top on a closed unit that was not deactivated and the fryer was not under the hood extinguishing system. This deficient practice was rectified immediately by placing a shut off switch to the cook top and secured it with a master lock. The fryer was moved under the hood. **(Attachment A and B).** **Measures in place/system changes:** The Director of Maintenance or designee provided the picture of the cook top with the switch and securement device. An addition picture of the fryer under the hood extinguishing system. The Director of Maintenance or designee will complete audits weekly for four weeks and then monthly for four months. This will be reviewed at the Quality Improvement meeting and will be reviewed monthly for five months. **Monitoring of corrective actions taken:** The Quality Assurance and Process Improvement committee will review compliance of K 324 Smoke Barriers monthly for (5) months at the scheduled QI meetings. Following five (5) monthly quality assurance compliance review and if no concerns are noted, the committee will file the audits. Date of Compliance February 13, 2023.	

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	Findings include: Based on observation with the Director of Plant Operations on 02/02/23 during a tour of the facility from 12:55 p.m. to 3:10 p.m., a deep fat fryer was not completely under the hood system and was not completely covered by the suppression system. Based on interview at the time of observation, the Director of Plant Operations agreed the fryer was not completely under the hood and stated the fryer will be put under the hood and suppression system before its next use. These findings were reviewed with the Director of Plant Operations, DON and Administrator during the exit conference. 3.1-19(b)			
K 0341 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8			
	Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was	K 0341	**K341** **Fire Alarm System**	02/13/2023

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	installed in accordance with 19.3.4.1. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 17.7.4.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 35 residents and staff in one smoke compartment. Findings include: Based on observation and interview during a tour of the facility with the Director of Plant Operations and Administrator on 02/02/23 between 12:55 p.m. and 3:10 p.m., in the Medical Records office there was a smoke detector located within 3 feet of an air return vent where air flow would prevent proper operation of the detector. Based on interview at the time of observation, the Director of Plant Operations confirmed a smoke detector was within 3 feet of air return vent in the Medical Records office. This finding was reviewed with the Director of Plant Operations, DON and Administrator at the exit conference. 3.1-19(b)		**This facility does ensure that smoke detectors are not within three feet of an air return, in accordance with the requirements of CFR(s): NFPA 101.** **Corrective actions taken:** The facility had a smoke detector within three feet of an air return. The facility moved the smoke detector so that it is more than three feet from an air return. A photograph is attached for reference. **(Attachment A).** **Measures in place/system changes:** The Director of Maintenance or designee provided the picture of the smoke detector that was moved to be further than 3 feet from the air return. This will be reviewed at the Quality Improvement meeting and will be reviewed monthly for five months. **Monitoring of corrective actions taken:** The Quality Assurance and Process Improvement committee will review compliance of K 341 Fire alarm system for (5) months at the scheduled QI meetings. Following five (5) monthly quality assurance compliance review and if no concerns are noted, the committee will file the audits. Date of Compliance February 13, 2023.	

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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
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that	K 0353	**K353** **Fire Alarm System** **This facility does ensure that sprinkler systems are inspected and tested for 4 of 4 quarters.** **In accordance with the requirements of CFR(s): NFPA 101.** **Corrective actions taken:** The facility had all sprinkler systems tested for four of four quarters last year. The facility had not placed the inspection for the last quarter in the life safety book. An inspection, testing, and maintenance invoice of the wet and dry pipe fire sprinkler systems was provided and is attached for reference. **(Attachment A).**	02/13/2023

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	155019	A. BUILDING 01 B. WING	02/02/2023

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	waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the quarterly sprinkler system inspection records on 02/02/23 from 9:22 a.m. to 12:55 p.m. with the Director of Plant Operations, there was no quarterly sprinkler system inspection report available for the fourth quarter (October, November, and December) of 2022. The sprinkler system was last inspected on 08/18/22. During an interview at the time of record review, the Director of Plant Operations stated the sprinkler system was 'blown out' by their sprinkler system inspection vendor, and confirmed there was no written documentation available to show the sprinkler system had been inspected during the fourth quarter of 2022. This finding was reviewed with the Director of Plant Operatons, DON and Administrator at the exit conference. 3.1-19(b)		**Measures in place/system changes:** The Director of Maintenance has provided the inspection. This will be reviewed at the Quality Improvement meeting and will be reviewed monthly for five months. **Monitoring of corrective actions taken:** The Quality Assurance and Process Improvement committee will review compliance of K 353 Fire alarm system for (5) months at the scheduled QI meetings. Following five (5) monthly quality assurance compliance review and if no concerns are noted, the committee will file the audits. Date of Compliance February 13, 2023.	
K 0372 SS=B Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING			

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	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 openings through 1 of 1 ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect over 20 residents and staff in the vicinity of resident room 503. Findings include: Based on observation with the Director of Plant Operations and Maintenance Assistant during a tour of the facility from 12:55 p.m. to 3:10 p.m. on 02/02/23, the approximate 2' X 2' attic access panel above the suspended ceiling tiles by resident room 503 was lying to the side of the opening which exposed the attic above. Based on interview at the time of the observation, the	K 0372	**K372** **Smoke Barrier** **This facility does ensure that Smoke Barrier walls are in accordance with the requirements of CFR(s): NFPA 101. Corrective actions taken:** The facility had a 2 X 2' attic access panel above the suspended ceiling tiles by Resident room 503 that was lying to the side of the opening which exposed the attic above. This deficient practice was rectified immediately and was closed. **(Attachment A).** **Measures in place/system changes:** The Director of Maintenance or designee provided the picture of the Smoke barrier attic access panel identified. This will be reviewed at the Quality Improvement meeting and will be reviewed monthly for five months. **Monitoring of corrective actions taken:** The Quality Assurance and Process Improvement committee will review compliance	02/13/2023

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	Director of Plant Opertations confirmed the attic access panel being open in the ceiling did not ensure the ceiling smoke barrier was protected to maintain the fire resistance rating of the smoke barrier. The Maintenance Assistant placed the attic access panel back into the opening at the time of observation. This finding was reviewed with the Administrator, Director of Plant Operations and DON during the exit conference. 3.1-19(b)		of K 372 Smoke Barriers monthly for (5) months at the scheduled QI meetings. Following five (5) monthly quality assurance compliance review and if no concerns are noted, the committee will file the audits. Date of Compliance February 13, 2023.	
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 accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review and interview; the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance within the most recent four year period 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. The test and inspection frequency shall be every 4 years. If the damper is equipped with a fusible link, the link shall be removed for	K 0521	**K 521** **HVAC** **This facility does ensure that the dampers are inspected in accordance with the requirements of CFR(s): NFPA 101.** **Corrective actions taken:** The facility ensures that dampers are inspected and has requested an itemized list from the contracted HVAC company. An inspection, testing, and maintenance invoice of the itemized dampers will be provided and is attached for reference. **(Attachment A).** **Measures in place/system changes:** The Director of	02/18/2023

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	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. Section 19.4.3 states full unobstructed access to the fire damper shall be verified and corrected as required. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of undated HVAC contractor documentation with the Director of Plant Operations from 9:22 a.m. to 12:55 p.m. on 02/02/23, documentation of fire damper inspection and testing within the most recent four year period was not itemized by location. The document stated "Lowers HVAC LLC did the 2022 check on all fire dampers and fuse links within dampers for the Bloomington facility. We replaced some as needed, all are now in good condition and operational." During interview at the time of record review, the Director of Plant Operations stated documentation of an itemized listing of all fire damper inspection and testing in the facility within the most recent four year period was not available for review at the time of the survey. This finding was reviewed with the Director of Plant Operations, DON and Administrator at the exit conference. 3.1-19(b)		Maintenance or designee has requested the damper inspection itemized list from the contracted HVAC vendor. This will be reviewed at the Quality Improvement meeting and will be reviewed monthly for five months. **Monitoring of corrective actions taken:** The Quality Assurance and Process Improvement committee will review compliance of K 521 HVAC for (5) months at the scheduled QI meetings. Following five (5) monthly quality assurance compliance review and if no concerns are noted, the committee will file the audits. Date of Compliance February 18, 2023.	
K 0754 SS=B	NFPA 101 Soiled Linen and Trash Containers			

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Bldg. 01	Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7			
	Based on observation and interview, the facility failed to ensure trash receptacles in 1 of 5 corridors were maintained in accordance with 19.7.5.7. This deficient practice could affect staff and up to 35 residents and staff in Station 4. Findings include: Based on observations with the Director of Plant Operations on 02/02/23 during a tour of the facility from 12:55 p.m. to 3:10 p.m., there was an unattended 55 gallon soiled linen/trash barrel outside of the soiled utility room on Station 4. Based on interview at the time of observation, the Director of Plant Operations agreed the unattended barrel was greater than 32-gallon and placed the barrel in the soiled linen room at the time of observation. This finding was reviewed with the Director of	K 0754	**K 754** **Soiled Linen** **This facility does ensure that the soiled linen is kept in soiled utility room, in accordance with the requirements of CFR(s): NFPA 101.** **Corrective actions taken:** The facility ensures that soiled linens are kept in soiled utility rooms until taken to laundry. The Director of maintenance or designee with conduct audits of K754 weekly for four weeks and monthly for four months. **(Attachment A).** **Measures in place/system changes:** The Director of Maintenance or designee is doing audits of soiled linen barrels. This	02/13/2023

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	Plant Operations, DON and Administrator during the exit conference. 3.1-19(b)		will be reviewed at the Quality Improvement meeting and will be reviewed monthly for five months. **Monitoring of corrective actions taken:** The Quality Assurance and Process Improvement committee will review compliance of K 754 soiled linens for (5) months at the scheduled QI meetings. Following five (5) monthly quality assurance compliance review and if no concerns are noted, the committee will file the audits. Date of Compliance February 13, 2023.	