STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155556	A. BUILDING -- B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF TIPTON SKILLED NURSING FACILITY, THE	300 FAIRGROUNDS RD TIPTON, IN 46072

(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: 03/21/24 Facility Number: 000505 Provider Number: 155556 AIM Number: 100266350 At this Emergency Preparedness survey, The Waters of Tipton Skilled Nursing Facility was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 150 and had a census of 89 at the time of this survey. Quality Review completed on 03/22/24	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: 03/21/24 Facility Number: 000505 Provider Number: 155556 AIM Number: 100266350 At this Life Safety Code survey, The Waters of Tipton Skilled Nursing Facility was found not in compliance with Requirements for Participation in	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Victoria Roe	Administrator	04/16/2024

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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	155556	A. BUILDING 01 B. WING	03/21/2024

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WATERS OF TIPTON SKILLED NURSING FACILITY, THE	300 FAIRGROUNDS RD TIPTON, IN 46072

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	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 two 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, areas open to the corridors and battery operated smoke detectors in the resident sleeping rooms. The facility has a capacity of 150 and had a census of 89 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 03/22/24			
K 0341 SS=F 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	K 0341	**Preparation and/or execution**	04/21/2024

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	failed to ensure 2 of 2 fire alarm control units, located in an area that was not continuously occupied, was provided with annunciation readily accessible to responding personnel to facilitate an efficient response to the fire situation. 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 and Signaling Code. NFPA 72, 2010 Edition, Section 10.16.3.1 states all required annunciation means shall be readily accessible to responding personnel. Section 10.16.3.2 states all required annunciation means shall be located as required by the authority having jurisdiction to facilitate an efficient response to the fire situation. Section 10.12.5 states the trouble signal(s) shall be located in an area where it is likely to be heard. Annex A is not a part of the requirements but is included for informational purposes only Section A.10.16.3 states the primary purpose of fire alarm system annunciation is to enable responding personnel to identify the location of a fire quickly and accurately and to indicate the status of emergency equipment or fire safety functions that might affect the safety of occupants in a fire situation. This deficient practice could affect all patients, staff and visitors in the facility. Findings include: Based on observations with the Maintenance Director and the Administrator on 03/21/24 at 2:40 p.m., the main fire alarm control unit was in the mechanical room and a remote annunciator was in the front foyer. Both areas are only occupied during business hours and not continuously occupied. Based on interview at the time of the observations, the MD agreed the main panel and		**of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.** It is the intent of the facility to ensure fire alarm control units, located in an area that was not continuously occupied, is provided with annunciation readily accessible to responding personnel to facilitate an efficient response to the fire situation to meet set standards. **CORRECTIVE ACTIONS TAKEN**: The facility will have the fire panel relocated on 4/19/2024 to an area that is visible to a nurses station that is staffed at all hours. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: All residents and all staff and visitors have the potential to be affected but none were. **MEASURES TO PREVENT REOCCURRENCE**: The fire panel will be located in an area of the facility that is staffed 24/7.	

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	remote panel were not in areas continuously occupied and stated there in no remote annunciator in the continuously occupied areas of the building. The finding was reviewed with the Administrator and the MD during the exit conference. 3.1-19(b)		**MONITORING CORRECTIVE ACTION**: The inspection results will be presented by the DON/nursing staff/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 4/21/2024.**	
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			

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	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 1. Based on record review and interview, the facility failed to maintain 2 of 2 sprinkler systems in accordance with 19.3.5.3. NFPA 25, 2011 Edition, 14.2.1 states except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director (MD) on 03/21/24 at 12:30 p.m., the internal inspection of piping documentation was not available for review. Based on interview at the time of record review, the MD agreed the internal inspection documentation was not available for review. There was a 5 year internal pipe inspection tag on the riser that was dated 4/14/18 which is over 5 years old. This finding was reviewed with the Administrator and MD at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 wet sprinkler system was provided with spare sprinklers, a spare sprinkler cabinet large enough to fit all spare sprinkler heads, and a sprinkler wrench on the	K 0353	**Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.** It is the intent of the facility to ensure to maintain sprinkler systems in accordance with 19.3.5.3 and to ensure wet sprinkler systems are provided with spare sprinklers, a spare sprinkler cabinet large enough to fit all spare sprinkler heads, and a sprinkler wrench on the premises to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 4/16/2024 the facilities licensed sprinkler contractor will complete the 5 year internal pipe inspection to meet set standards. The Administrator will verify the work on 4/17/2024 .	04/16/2024

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	premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observation with the MD on 03/21/24 at 3:05 p.m., the 2 spare sprinkler cabinets in the riser room did not include ordinary (red liquid) pendant sprinkler heads. During the facility tour there were many ordinary pendant sprinkler heads throughout the facility. Based on interview at the time of the observations, the Maintenance Director agreed the spare sprinkler cabinet did not contain all types of spare sprinkler heads utilized in the facility. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		2.On 04/04/2024 the Maintenance Supervisor will ensure to have all types of spare sprinkler heads in the spare sprinkler cabinet that are utilized in the facility to meet set standards. The Administrator verified this on 4/4/2024. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 04/04/2024 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to maintain sprinkler systems and to ensure the spare sprinkler cabinet has all types of spare sprinkler heads utilized in the facility to meet set standards. 2.Maintenance Supervisor/designee will ensure to maintain sprinkler systems and to ensure the spare sprinkler cabinet has all types of spare sprinkler heads utilized in the facility as a part of the facility's Monthly 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.	

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			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 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 04/16/2024.**	
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			

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	compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 2 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 4 residents.	K 0363	**Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this**	04/08/2024

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	Findings include: Based on observation with the Administrator and Maintenance Director (MD) on 03/21/24 at 2:00 p.m. and 3:00 p.m., the corridor door to resident sleeping room 28 and 69 would not close and latch into the frame when tested. Based on interview at the time of observation, the MD agreed the corridor door to room 28 and 69 would not close and latch into the door frame. These findings were reviewed with the Administrator and MD during the exit conference. 3.1-19(b)		**statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.** It is the intent of the facility to ensure corridor doors are provided with a means suitable for keeping the door closed, have no impediments to closing, latching and would resist the passage of smoke to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On 3/21/2024 the Maintenance Supervisor/designee repaired the corridor door to resident sleeping room 28 & 69 to ensure the doors fully close and latch into the frame to meet set standards. The Administrator verified the repairs on 3/22/2024 . **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 to ensure they close and latch into the frame and found no other negative findings. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 04/04/2024 the	

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			Administrator in serviced the Maintenance Supervisor/designee on the requirement that corridor doors must fully close and latch into the frame to meet set standards. b Maintenance Supervisor/designee will inspect all corridor doors throughout the facility monthly to ensure they fully close and latch into the 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 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	

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			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 04/8/2024**	
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 penetrations through 1 of 8 smoke barrier walls was protected to maintain the smoke resistance of each 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. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires,	K 0372	**Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction**	04/08/2024

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	and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 20 residents in two smoke compartments. Findings include: Based on observation with the Maintenance Director (MD) on 03/21/24 at 3:20 p.m., the smoke barrier wall above the smoke barrier doors by the conference room, there was a 3/4 inch gap around a piece of flexible conduit. Based on interview at the time of observation, the MD agreed there was a 3/4 inch unsealed penetration in the smoke barrier above the smoke barrier doors by the conference room. The finding was reviewed with the MD and the Administrator during the exit conference. 3.1-19(b)		**constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.** It is the intent of the facility to ensure penetrations through smoke barrier walls are protected to maintain the smoke resistance of each smoke barrier to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On 03/22/2024 the Maintenance Supervisor/designee sealed the 3/4 inch gap in the smoke barrier wall above the smoke barrier doors by the conference room with a one hour fire rated material to meet set standards. The Administrator verified the work on 03/22/2024. **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 3/22/2024 the Maintenance Supervisor/designee inspected all smoke barrier walls and ceilings throughout the facility for penetrations and found no other negative findings. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 04/04/2024 Administrator in serviced the Maintenance Supervisor/designee on the requirement that smoke barriers walls are constructed to	

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WATERS OF TIPTON SKILLED NURSING FACILITY, THE	300 FAIRGROUNDS RD TIPTON, IN 46072

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			provide at least a one half hour resistance rating and ceilings must be free from penetrations to meet set standards. b Maintenance Supervisor/designee will inspect all smoke barrier walls and ceilings throughout the facility monthly to ensure they remain free of penetrations 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 01 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF TIPTON SKILLED NURSING FACILITY, THE	300 FAIRGROUNDS RD TIPTON, IN 46072

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			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 04/08/2024.**	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of over 20 ground fault circuit interrupter (GFCI) was properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could affect 3 residents. Findings include: Based on observation with the Maintenance Director (MD) on 03/21/24 at 2:55 p.m. when the GFCI receptacle located within 6 feet feet from the sink in the Aviary kitchenette was tested with a GFCI tester the electric receptacle did not trip. Based on interview at the time of observation, the MD agreed the GFCI electric receptacle within 6 feet of the sink in the Aviary Kitchenette did not trip when tested.	K 0511	**Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.** It is the intent of the facility to ensure ground fault circuit interrupter (GFCI) is properly maintained for protection against	04/08/2024

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	This finding was reviewed with the Administrator and the MD during the exit conference. 3.1-19(b)		electric shock to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: A. On 3/21/2024 the Maintenance Supervisor replaced the GFCI receptacle located in the Aviary Kitchenette to meet set standards. The Administrator verified the work on 3/22/2024. **1.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **2.MEASURES TO PREVENT REOCCURRENCE**: 1.On 04/04/2024 the Administrator inserviced the Maintenance Supervisor/designee on the requirement to ensure all GFCI receptacles are properly maintained for protection against electric shock to meet set standards. 2.Maintenance Supervisor/designee will ensure all GFCI receptacles are properly maintained for protection against electric shock as a part of the facility's monthly 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	

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			monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **3.MONITORING CORRECTIVE ACTION**: 1.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 04/08/2024.**	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with			

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	signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on observation and interview; the facility failed to ensure 2 of 3 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect staff and 6 residents and staff in the smoking areas. Findings include: Based on observation during a tour of the facility with the Maintenance Director (MD) and Administrator on 03/21/24 at 2:20 p.m., in two of the smoking areas, there were over 30 cigarette butts disposed on the ground in and around the smoking areas by the front entrance and by door 6. Based on interview at the time of observations, the Maintenance Director agreed there were cigarette butts on the ground in the	K 0741	**Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.** It is the intent of the facility to ensure smoking areas are	04/08/2024

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	aforementioned locations. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 3/21/2024 the Administrator/DON/Maintenance Supervisor/designee removed the cigarette butts from the ground in and around the smoking areas by the front entrance and by door 6 to meet set standards. The Administrator verified the work on 3/22/2024 . 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 04/04/2024 the Administrator in serviced all staff on the requirement to ensure metal containers with self-closing lids are located in smoking areas to meet set standards. b Maintenance Supervisor/designee will ensure metal containers with self-closing lids are present in all smoking areas per the facility's Smoking Policy 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	

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			inspection results. c The Administrator will monitor adherence to the Smoking Policy 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 04/08/024.**	