STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155238	A. BUILDING -- B. WING	09/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
YORKTOWN MANOR	2000 S ANDREWS RD YORKTOWN, IN 47396

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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: 09/05/23 Facility Number: 000143 Provider Number: 155238 AIM Number: 100283890 At this Emergency Preparedness survey, Yorktown Manor was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 100 certified beds. At the time of the survey, the census was 64. Quality Review completed on 09/07/23	E 0000	K 000 By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective September 14, 2023, to the Life Safety Code Recertification and State Licensure with Emergency Preparedness Survey completed on September 5, 2023. We respectfully request a desk review for paper compliance.	
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: 09/05/23 Facility Number: 000143 Provider Number: 155238 AIM Number: 100283890 At this Life Safety Code survey, Yorktown Manor was found not in compliance with Requirements	K 0000	K 000 By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Bailey	Administrator	09/14/2023

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	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 (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery-operated smoke detectors in all resident sleeping rooms and office areas. The facility has a capacity of 100 and had a census of 64 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except detached a metal storage building. Quality Review completed on 09/07/23		September 14, 2023, to the Life Safety Code Recertification and State Licensure with Emergency Preparedness Survey completed on September 5, 2023. We respectfully request a desk review for paper compliance.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 6 corridor means of egresses was continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following	K 0211	K 211 Means of Egress The PPE cart observed during the survey was removed from the hall near the employee breakroom and replaced with PPE cart equipped with wheels. Maintenance	09/14/2023

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	conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect 15 residents if needing to exit the facility. Findings include: Based on an observation and interview during a tour of the facility with the Maintenance Director on 09/05/23 between 11:30 a.m. and 12:50 p.m., in the hall near the Employee Breakroom, a Personal Protective Equipment (PPE) cart was being stored and was not equipped with wheels allowing the carts to be moved out of the hall during an emergency. The Maintenance Director stated that the PPE cart observed was deployed during the weekend when the facility suspected a resident had contracted COVID. Based on an interview at the time of observations, the Maintenance Director stated the PPE cart was not equipped with wheels and would need to be replaced with a PPE cart with wheels or removed. The finding was reviewed with the Maintenance Director at the time of discovery and again with the Administrator and Maintenance Director present during the exit conference. 3.1-19(b)		evaluated all PPE carts in storage and removed all carts without wheels. Facility has replaced non-moveable carts to carts with wheels to meet qualifications. Maintenance has added weekly checks for all PPE carts to ensure wheels are present and working properly. Concerns noted will be addressed immediately and all monitoring will be reviewed monthly with the Administrator and quarterly with QA. As evidence of correction, a picture of cart and tracking log has been attached.	

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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 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			

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	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 4 facility exits was 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 or special knowledge from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 25, staff and visitors if needing to exit the facility. Findings include:	K 0222	K 222 Egress Doors All doors observed during the survey and additional doors were evaluated and 4-digit code was typed for clear display and posted securely to control box located at each facility exit door. Codes are placed at eye level and in clear sight for exit. Maintenance has included daily checks to ensure code remains present and clear visual sight. All concerns will be addressed immediately. The administrator will review logs monthly. Monitoring logs will be	09/14/2023

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	Based on an observation and interview during a tour of the facility with the Maintenance Director on 09/05/23 between 11:30 a.m. and 12:50 p.m., the (1) Main Entrance/Exit door, marked as a facility exit, was magnetically locked and could be opened by entering a four-digit code but the code was not posted at the exit. Furthermore, the exit doors near (2) resident room 311 and (3) resident room 413, were magnetically locked and could be opened by entering a four digit code, but the code was not posted in such a manner that it would not require special knowledge to find the code. The code was posted on the door in the corner of the window sight glass and was pointed out by the Maintenance Director. And the (4) service exit door, was magnetically locked and could be opened by entering a four-digit code, but the code as not posted. The Maintenance Director pointed to a sign on a bulletin board in the corridor which instructed those wanting to exit to type in specific digits in the facilities phone number. The Maintenance Director agreed that this practice would require special knowledge to find the instructions and then to know the phone number. The finding was reviewed with the Maintenance Director at the time of discovery and again with the Administrator and Maintenance Director present during the exit conference. 3.1-19(b)		presented quarterly with QA. As evidence of correction, a picture of exit door signage has been attached with monitoring log.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in			

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	accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage room, was provided with a properly working self-closing device. This deficient practice could affect more than 5 staff in the kitchen area. Findings include: Based on an observation and interview during a tour of the facility with the Maintenance Director on 09/05/23 between 11:30 a.m. and 12:50 p.m., the	K 0321	K 321 Hazardous Areas Enclosure Observation during survey 1 of 10 hazardous area doors did not close according to self-closing devise and latch. Maintenance has adjusted closure on door. The storage room in kitchen does close as latch with accordance of self-closing guidance. Maintenance evaluated other hazardous storage areas with no concerns noted. Maintenance will	09/14/2023

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	door to the kitchen mop storage closet, containing hazardous chemicals, equipped with a self-closing device, however, failed to self-close and latch positively into the door frame when tested. Based on interview at the time of the observation, the Maintenance Director agreed the door did not self-close and latch into the door frame. The finding was reviewed with the Maintenance Director at the time of discovery and again with the Administrator and Maintenance Director present during the exit conference. 3.1-19(b)		monitor all hazardous doors daily to ensure self-closure is working correctly and door laches with accordance. Any concerns will be addressed immediately. The administrator will review logs monthly and QA quarterly. As evidence of correction, a picture of closed and latched door has been attached with monitoring log.	
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			

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	Based on observation and interview, the facility failed to install the kitchen range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 edition, Section 6.2.4.1 states kitchen range hood system filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). This deficient practice could affect up to 6 staff in the kitchen area. Findings include: Based on an observation and interview during a tour of the facility with the Maintenance Director on 09/05/23 between 11:30 a.m. and 12:50 p.m., the design of the kitchen hood requires two drip trays, one on each side. Only the right side contained a drip tray, the left side was missing its metal drip tray underneath the kitchen range hood system. The Maintenance Director searched the kitchen but was unable to locate the missing try, and agreed the try was missing on the left side of the appliance. The finding was reviewed with the Maintenance Director at the time of discovery and again with the Administrator and Maintenance Director present during the exit conference. 3.1-19(b)	K 0324	K 324 Cooking Facilities During observation of kitchen hood during survey, left side drip tray was not present to kitchen hood range. Facility contacted and drip pan for left side of range hood was purchased. Maintenance installed drip pan. Maintenance will monitor 2x weekly for 2 weeks and then monthly to ensure drip pan remains in place. Any concerns will be corrected immediately. Administrator will review monitoring monthly and quarterly with QA. As evidence of correction, a picture of drip pan in place has been attached with monitoring log.	09/14/2023
K 0345 SS=F	NFPA 101 Fire Alarm System - Testing and			

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Bldg. 01	Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff and visitors. Findings include: Based on an observation and interview during a tour of the facility with the Maintenance Director on 09/05/23 between 11:30 a.m. and 12:50 p.m., the date and time on the main fire alarm control panel were incorrect. The display on the main fire alarm control panel indicated the time to be approximately 8-9 hours slower than the actual local time. Furthermore, the date on the panel showed it to be 01/27/2009 and not the correct date of 09/05/23. Based on interview at the time of observation, the Maintenance Director indicated he was aware of the discrepancy and had spoken with the vendor but was unsure how to correct the issue himself and was waiting on the vendor to come and reset the panel. The finding was reviewed with the Maintenance Director at the time of discovery and again with	K 0345	K 345 Fire Alarm System – Testing and Maintenance During the tour of the facility, it was observed fire alarm system was inaccurate with date and time. Safe Care was contacted, and correct date, time and year was reset. The panel was checked for malfunction with no concerns noted. Maintenance will monitor panel weekly to ensure correct information remains displayed. Any malfunctions will be immediately corrected. The administrator will review logs monthly and quarterly with QA. As evidence of correction, a picture of drip pan in place has been attached with monitoring log.	09/14/2023

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	the Administrator and Maintenance Director present during the exit conference. 3.1-19(b)			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, 5.2.2.2 requires sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect 20 residents in one smoke compartment. Findings include:	K 0353	K 353 Sprinkle System – Maintenance and Testing During the survey it was observed in an attic near the main nurses' station, wires resting on sprinkler pipes. Safe Care was contacted to assist with proper placement of wires. Wires were effectively removed from sprinkler pipes and secured. Maintenance to evaluate other areas of attic. No further concerns noted. Maintenance will monitor monthly all wiring in attic to ensure it remains secure and	09/14/2023

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	Based on an observation and interview during a tour of the facility with the Maintenance Director on 09/05/23 between 11:30 a.m. and 12:50 p.m., the attic near the main nurse's station contained several wires which were resting on sprinkler pipes. Additionally, some wires were zip-tied (with a pink zip tie) to the vertical sprinkler pipe which ran directly to the sprinkler heads. The Maintenance Director agreed wires were laying on the sprinkler pipes in the attic and that some wires were zip-tied to the sprinkler pipe itself. The finding was reviewed with the Maintenance Director at the time of discovery and again with the Administrator and Maintenance Director present during the exit conference. 3.1-19(b)		not resting on pipes. Maintenance to ensure when outside contractors complete work in attic that all areas are checked and approved per guidance. Areas of concern will be addressed immediately and corrected. The administrator will review logs monthly and quarterly with QA. As evidence of correction, a picture of drip pan in place has been attached with monitoring log.	