STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155496	A. BUILDING -- B. WING	05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	333 W MISHAWAKA RD ELKHART, IN 46517

(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: 05/13/24 Facility Number: 000523 Provider Number: 155496 AIM Number: 100266930 At this Emergency Preparedness survey, Valley View Healthcare Center, was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 94 certified beds. At the time of the survey, the census was 83. Quality Review completed on 05/16/24	E 0000	/p>	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
David Henke	Executive Director	05/28/2024

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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	HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training.			

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	(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training.			

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	(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies			

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	and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility	E 0037	The facility did have an emergency	05/30/2024

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	failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect approximately all residents, staff and visitors. Findings include: Based on record review with the Administrator-in-Training and Maintenance Director on 05/13/24 between 08:48 a.m. and 12:28 p.m., no documentation of annual EEP training and no documentation to show staff could demonstrate knowledge of the EPP was available for review. During record review, a template used for emergency preparedness training was provided indicating the facility has a way of testing staff, but testing forms that were completed by staff could not be produced. Based on interview at the time of record review, the Administrator-in-Training acknowledged that the proper training documentation could not be located during the survey. She further stated that all staff initially go through training at orientation and every year after, however it's documented in other files that could not be produced during the survey. This finding was reviewed with the Administrator-in-Training and Maintenance Director during the exit conference.		occurrence all residents had the potential to be affected. Exhibit D. The Emergency Preparedness System and policy book was reviewed at the manager's meeting as well as the QAPA Committee meeting on 5/24/24 Exhibit D The areas covered included emergency preparedness, weather emergencies, emergency supplies, County resources, staffing, food and medical supplies, evacuation of the facility. Staff were inserviced during the week of 5/18/2024 on emergency plans and utility shut off/disruption. Elopement and fire drills are routine according to regulation. The facility does attend in person or by zoom the Elkhart County Emergency Management drill and community emergency planning Exhibit A. The Emergency Preparedness manuals are located at the nursing station, the Executive Director's office and the Maintenance Department. The facility did have a table top emergency review on 5/24/24 Exhibit C. The facility will continue to be an active part of the Elkhart County Emergency Preparedness plan with a scheduled drill Fall of 2024. Audits will be completed quarterly and ongoing assuring the facility continues to participate in the County Preparedness Plan and actively participates in the offered	

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			simulation. This audit and update will be the attachments/handouts from the meetings and communicated through the QAPI Committee by the Director of Maintenance/designee. Desk Review Requested	
E 0039 SS=F 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), §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			

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	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 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			

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	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. (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			

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	(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 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			

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	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: (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			

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	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 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			

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	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, 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			

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VALLEY VIEW HEALTHCARE CENTER	333 W MISHAWAKA RD ELKHART, IN 46517

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	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 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			

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	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 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			

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	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 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:	E 0039	No residents were harmed by the deficiency cited. The facility did have an emergency occurrence and no residents were physically harmed yet all residents had the potential to have been affected. The facility did have an active emergency occurrence on December 29th of 2023 Exhibit D. The facility followed the emergency policies and managed accordingly. The occurrence was well documented and signatures collected reflecting the incident, the review and training as well as the oversite from corporate risk management. Staff were inserviced during the week of 5/18/2024 on emergency plans and utility shut off/disruption posttest Exhibit B. The facility does attend in person or by zoom the Elkhart County Emergency Management drills, Exhibit A. The documentation has been attached, Exhibits A, B &C. The Emergency Preparedness manuals are located at the nursing station, the Executive Director's office and the Maintenance Department. The facility did have a table top emergency review on 5/18/24 Exhibit D. The facility will continue to be an active part of the Elkhart County Emergency Preparedness plan with a scheduled drill Fall of 2024.	05/30/2024

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	Based on record review with the Administrator-in-Training and the Maintenance Director on 05/13/24 between 08:48 a.m. and 12:28 p.m., a real severe weather event had been provided by the facility dated 12/22/23, however documentation for a second exercise of choice could not be provided during the survey. Based on interview at the time of record review, the Administrator-in-Training acknowledged the missing drill and was unsure where the second piece of documentation could be. Findings were reviewed with the Administrator-in-Training and Maintenance Director at exit conference.		Audits will be completed quarterly and ongoing assuring the facility continues to participate in the County Preparedness Plan and actively participates in the offered simulation. This audit and update will be communicated through the QAPI Committee by the Director of Maintenance/designee Desk Review Requested	
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: 05/13/24 Facility Number: 000523 Provider Number: 155496 AIM Number: 100266930 At this Life Safety Code survey, Valley View Healthcare Center 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	K 0000	/p>	

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	Type V (111) construction and was fully sprinklered. The 500, 600, and 700 Hall Units, which are in the southern portion of the facility, are decommissioned and do not have any residents living in them. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors, and 1 resident room. Battery operated smoke detectors are provided in 74 of 75 rooms resident rooms. The facility is fully protected by a 75 kW natural gas generator. The facility has a capacity of 94 beds dually certified for Medicare and Medicaid. At this survey the facility had a census of 83. All areas where residents have customary access were sprinklered. The facility has a detached garage providing storage of maintenance equipment and a shed containing storage of wheel chairs and walkers which were not sprinklered. Quality Review completed on 05/16/24			
K 0161 SS=E Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories			

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	sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. Based on observation and interview, the facility failed to maintain the building construction type in 1 of over 100 rooms. This deficient practice could affect approximately 15 residents and staff. Findings include: Based on observation during a tour of the facility on 05/13/24 between 12:34 p.m. and 3:10 p.m. with the Maintenance Director and Administrator-in-Training, the 300-Hall shower room had approximately 3, 1 inch ceiling penetrations from a previous fan. The holes did expose the attic space above. Based on interview at the time of observation, the Maintenance Director confirmed the ceiling penetrations in the room and stated a ventilation fan used to be	K 0161	No residents were harmed by this cited deficiency All residents using this space had the potential to be affected. The 3 one-inch holes in found in the 300 shower room were sealed with fire resistant caulk. A new fan was received and placed in this area. Room readiness audit will include shower rooms. Maintenance staff providing these audits were educated on observations for breech of fire barriers Exhibit E. The TELS work order system will be utilized to manage the audits and needed repairs according to	05/30/2024

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	installed, however it stopped working and was taken down. The Maintenance Director then stated the fan is planned to be replaced. The finding was discussed with the Maintenance Director and Administrator-in-Training at exit conference 3.1-19(b)		regulations. The TELS work order system will be monitored for compliance monthly by the Executive Director/designee for timely completeness of work and correct prioritization of work orders. This is an ongoing audit reported through the TELS work order system and reviewed by the QAPI Committee. Desk Review Requested	
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			

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	release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted 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 2 of 7 delayed egress locking arrangements were installed in accordance with	K 0222	No residents were harmed for this cited deficiency. Any resident attempting to EXIT	05/30/2024

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	LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect approximately 10 residents and staff. Findings include: Based on observation during a tour of the facility with the Maintenance Director and Administrator-in-Training on 05/13/24 between 12:34 p.m. and 3:10 p.m., the emergency exit door adjacent to the oxygen storage/transfilling room along with the emergency exit near resident room 214 were posted as emergency exits, contained signage indicating it had a 15 second delayed egress function. When the door was tested, the 15 second delay did not initiate after testing three times. Based on interview at the time of observation, the Maintenance Director acknowledged that the doors delayed egress function did not initiate and was unsure why it was not working. The findings were reviewed with the Maintenance Director and the Administrator-in-Training during		the two identified doors could have been affected during and emergency requiring the use of these two EXITS. No such emergency occurred during that period The EXIT doors identified as the employee entrance near the oxygen storage room and the end-of-hall EXIT on 200 Hall were reprogrammed to provide egress release within 15 seconds according to regulation. Maintenance staff were educated by the Executive Director regarding the proper door inspection and monthly check assignment Exhibit E. All EXIT doors are tested for function including closure, latching and egress. The audit is recorded on the TELS work order management system. Any necessary repairs are documented for timely repair. Will be Improper functioning doors will be brought to the attention of the Executive Director/designee for timely attention. The incidences will be reported through the QAPI Committee as well as the Divisional Facilities Director. Desk Review Requested	

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	the exit conference. 3.1-19(b)			
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of 48 of 48 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect approximately all residents, staff and visitors. Findings include: Based on records review with the Maintenance Director and Administrator-in-Training on 05/13/24 between 08:48 a.m. and 12:28 p.m., battery smoke detector testing had been produced during the survey, however, were missing weekly inspections. Missing inspections included all of	K 0300	No residents were harmed by this cited deficiency All residents had the possibility to be affected however no fire incidences occurred during this period. The Maintenance staff were educated by the Executive Director regarding the testing of all smoke detectors, Exhibit E. The weekly testing required is assigned through the TELS work flow system and necessary documentation is inputted on that app. The TELS workflow management system will be monitored monthly by the Executive Director/Designee for the completion of this task. Any smoke detector found to be not functioning will be immediately replaced. All such incidences will be reported through the QAPI Committee for trending. Desk Review Requested	05/30/2024

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	March 2024, December 2023 and September 2023. January-February 2024 was missing certain weeks as well. Based on interview at the time of record review, the Maintenance Director acknowledged the missing inspections and stated time constraints left some of the documentation not filled out. He further stated that he was unaware that weekly testing was required. During a tour of the facility later during the survey, the smoke detectors located in resident rooms 205, 207 and 209 all had manufacturer's instructions indicating weekly testing was required. Findings were discussed with the Maintenance Director and Administrator-in-Training at exit conference. 3.1-19(b)			
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler			

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	Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 5 overhangs in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. This deficient practice could affect approximately 20 residents, staff and visitors. Findings include: Based on observation during a tour of the facility with the Maintenance Director and Administrator-in-Training on 05/13/24 between 12:34 p.m. and 3:10 p.m., approximately four sprinkler heads under an overhang at the main entrance were missing their escutcheon plates leaving annual space around the sprinkler heads. Based on interview at the time of observation, the Maintenance Director confirmed that the sprinkler heads were missing their escutcheon plates and further stated that the material was in the process of being obtained but had not been delivered at the time of the survey. Findings were reviewed with the Maintenance Director and Administrator-in-Training at exit conference. 3.1-19(b)	K 0351	No residents were harmed by this cited deficiency. Any resident could have been affected should a fire occurred in this specific area. No such incident occurred during this period. The escutcheons for the identified overhang were ordered prior to the survey through Safe Care and delivered 5/22/2024. The escustceons were placed in the identified area according to regulation on 5/28/2024. The Maintenance staff were educated on the purpose and use of escutcheons Exhibit E. The maintenance staff will monitor for missing escutchions during normal building weekly rounds. Any missing eschutcheons will be identified and replaced and entered into the TELS workflow system. See attachments The TELS workflow system will report through the QAPI Committee for reporting any missing escutcheons. Desk Review Requested	05/30/2024
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems			

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	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 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, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly, or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect approximately all residents. Findings include: Based on record review with the Maintenance	K 0353	No residents were harmed by this cited deficiency. All residents could have been affected should a fire have occurred and the system not functioned as designed. The Maintenance staff were educated by the Executive Director regarding the proper documentation of the monthly fire pipe inspection. Exhibit E The fire pipe inspections are assigned through the TELS workflow management system. Such documentation will be complete and available according to regulation. Any improper readings will be recorded and service called to Safe Care, the contracted fire repair company. Such incidents will be reported through the QAPI Committee and the Regional Facilities Director	05/30/2024

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	Director and Administrator-in-Training on 05/13/24 between 08:48 a.m. and 12:28 p.m., Gauge inspections for the dry sprinkler system were missing throughout the year. Most notably, the months of June & July of 2023 plus numerous weeks in August and September 2023 respectively. Based on interview at the time of record review, the Maintenance Director states that he conducts inspections weekly, however they are unable to document the inspections in time due to time constraints. He further stated that he had started his position at the end of last year, so everything before his time could not be accounted for. He later acknowledged and confirmed missing documentation and no other documentation could be found during the survey. Findings were discussed with the Administrator-in-Training and Maintenance Director at exit conference. 3.1-19(b)		See attachment Desk Review Requested	
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain			

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	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 3 of 48 resident room corridor doors in the facility 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 approximately 5 residents and staff. Findings include: Based on observation with the Maintenance Director and Administrator-in-Training on 05/13/24 between 12:34 p.m. 3:10 p.m., the corridor doors to resident rooms 412 and 109 did not latch	K 0363	No residents were harmed by this cited deficiency Three residents had the potential to be affected should a fire or smoke discharge have occurred. No such incident occurred during this period. The trash can in front of 413 was immediately moved. Doors to rooms 412 and 109 were replaced /repaired with new doors providing proper latching function. The Maintenance staff were educated on the door inspection guidelines	05/30/2024

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	into the frame when tested. Based on interview at the time of observation, the Maintenance Director stated the corridor door would not latch into the door frame because the latch was stuck inside the door. Furthermore, resident room 413 had a trash can propping the door open. The Maintenance Director confirmed that the trash can was propping the door open. Findings were reviewed with the Administrator-in-Training and the Maintenance Director during the exit conference. 3.1-19(b)		in addition to the priority of this Life Safety rule. Exhibit E All doors are inspected with any concern of proper function but no less than quarterly. The inspections are documented through the TELS workflow management system. The cited improper functioning doors were identified prior to the survey and were in process of replacement/repair. All improper functioning doors identified will be immediately communicated to the Executive Director/designee for timely repair and reviewed in the monthly QAPI committee meeting. See attachments, Desk Review Requested	
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 4 smoke barrier walls were protected to maintain the smoke	K 0372	No residents were harmed by this cited deficiency Any resident residing on the 400	05/30/2024

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	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, 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 approximately 20 residents and staff. Findings include: Based on observations with the Maintenance Director and Administrator-in-Training on 05/13/24 between 12:34 p.m. and 3:10 p.m., above the drop ceiling within the smoke barrier in the 200 Hall had electrical wires and conduit running through the barrier. The wires left an approximate 1 inch gap unsealed through the smoke barrier. Based on interview at the time of observation, the Maintenance Director confirmed the barrier penetration and would get the gap sealed. The finding was reviewed with the Administrator-in-Training and the Maintenance Director during the exit conference. 3.1-19(b)		hall could have been affected. The wires identified were placed in the conduit and the exterior of the conduit was sealed in the ceiling with fire resistant caulk. The Maintenance staff were educated in the identification and inspection of the sub-ceilings after work has been completed on those areas Exhibit E. The TELS workflow management system will be utilized to log such inspections and additionally assign the repair as a priority, The TELS work flow management system will be reviewed monthly for timely remedy of such occurrences and the completeness of tasks. See attachment, Desk Review Requested	

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K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure 1 of 2 electrical outlets in the Memory Care nurses station was protected. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect approximately 2 staff and an unknown number of residents. Findings include: Based on observation during a tour of the facility with the Maintenance Director and Administrator-in-Training on 05/13/24 between 12:34 p.m. and 3:10 p.m., an electrical outlet located inside the nurse's desk in the Memory Care wing was used to power electrical equipment, however it was missing a faceplate exposing wires inside the outlet. Based on interview at the time of observation, the Maintenance Director confirmed that the faceplate was missing and would have to be repaired. This finding was reviewed with the Administrator-in-Training and Maintenance Director at the exit conference. 3.1-19(b)	K 0511	No residents were harmed by this cited deficiency. The nursing station with outlet cover missing is in a locked station. No resident has access though a potential shock or short could have occurred. No such incident occurred during this period. The outlet covers was placed prior to the completion of the survey. The identified wire outside the electrical box was repaired by maintenance staff. The Maintenance staff were educated in the identification and inspection of the sub-ceilings after work has been completed Exhibit E. The TELS workflow management system will be utilized to log such inspections and additionally assign the repair as a priority, The TELS work flow management system will be reviewed monthly for timely remedy of such occurrences and the completeness of tasks. The review is shared through the monthly QAPI Committee. See attachment, Desk Review	05/30/2024

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	2. Based on observation and interview, the facility failed to ensure 1 of 1 electrical wirings in the 400 Hall were protected. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect approximately 15 residents and staff. Findings include: Based on observation during a tour of the facility with the Maintenance Director and Administrator-in-Training on 05/13/24 between 12:34 p.m. and 3:10 p.m., above the drop ceiling next to the smoke barrier doors, the wiring for the emergency exit light was not in a junction box and had its wires exposed and tied with wire nuts. Based on interview at the time of observation, the Maintenance Director confirmed that the wiring was exposed above the drop ceiling and not contained in a junction box. This finding was reviewed with the Administrator-in-Training and Maintenance Director at the exit conference. 3.1-19(b)		Requested.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between			

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	9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills on each shift for 1 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice could affect approximately all residents, staff and visitors. Findings include: Based on records review with the Maintenance Director and Administrator-in-Training on 05/13/24 between 08:48 a.m. and 12:28 p.m., no documentation was available to show a third shift fire drill for the first quarter of 2024 was conducted. Fire drills were recorded on an online program "TELS" which supposedly had a third shift drill within the quarter, however that drill had been conducted at approximately 8 p.m. which was during second shift and not third shift. Based on interview at the time of record review, the Maintenance Director acknowledged the missing fire drill and the wrong time for the third shift drill. This finding was reviewed with the Administrator-in-Training and Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	No residents were harmed by this cited deficiency All residents could have been affected if a fire incident had occurred. No such incident occurred during this period. The Maintenance staff were educated on the proper documentation of fire drills Exhibit E. All drills are documented on paper and transferred to the TELS work flow management system. Proper and timely documentation is necessary to meet this regulation. The TELS workflow management system will be utilized to log such inspections and additionally assign the repair as a priority. The TELS work flow management system will be reviewed monthly by the QAPI Committee for timely remedy of such occurrences and the completeness of tasks. Desk Review Requested	05/30/2024
K 0761 SS=E				

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Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 1 of 1 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is,	K 0761	No residents were armed by this cited deficiency All residents had the possibility to be affected. The oxygen storage door is a part of the monthly door inspection assignment. This specific door inspection was not documented to the satisfaction of the regulation. The maintenance staff were educated on the door inspection and proper documentation Exhibit E. The TELS workflow management system will be utilized to log such inspections and additionally assign the repair as a priority. The TELS work flow management system will be reviewed by the QAPI Committee monthly for timely remedy of such occurrences and the completeness of tasks. See attachment, Desk Review Requested	05/30/2024

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	the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect approximately 20 residents in one smoke compartment. Findings include: Based on record review with the Maintenance Director and Administrator-in-Training on 05/13/24 between 08:48 a.m. and 12:28 p.m., fire and smoke door assembly inspection documentation was available during the survey which was dated 04/12/24. However, the oxygen storage/transfilling room door had a missing inspection. During a tour of the facility between 12:34 p.m. and 3:10 p.m., the listed fire rating on the oxygen storage/transfilling room was 1-1/2 hours. Based on interview at the time of observation and record review, the Maintenance Director acknowledged the missing door inspection and stated he was unaware that the oxygen storage room door had to be inspected. Findings were reviewed with the Maintenance Director and Administrator-in-Training at exit conference. 3.1-19(b)			

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K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was	K 0918	No residents were harmed by this cited deficiency	05/30/2024

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	allowed a 5 minute cool down period after a load test. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110, 6.2.10 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect approximately all residents, as well as staff and visitors in the facility. Findings include: Based on record review with the Administrator-in-Training on 05/13/24 between 08:48 a.m. and 12:28 p.m., the generator log form titled "Monthly Generator Exercise and Inspection" had continuously listed the cooldown time at "0" seconds. Based on interview at the time of record review, the Maintenance Director confirmed that the documented cooldown time was 0 seconds. The Maintenance Director then described that the generator, once the 30 minute load test is completed, the generator shuts off and does not have a cooldown time after it runs under load. The Maintenance Director then acknowledged that the generator cooldown time should be at least 5 minutes. This finding was reviewed with the Maintenance Director and Administrator-in-Training at the exit conference. 3.1-19(b)		All resident could have been affected however no such incidents occurred during this period. The maintenance staff were educated on documentation of the 5-minute cool down period of the generator exercise Exhibit E. The cool down period is documented on the paper copy of the inspection. The paper copy of the exercise will be transferred to the TELS work flow management system. The TELS workflow management system will be utilized to log such exercises. The TELS work flow management system will be reviewed by the QAPI Committee monthly for timely remedy of such occurrences and the completeness of tasks. See attachment, Desk Review requested	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 01 B. WING	05/13/2024

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K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately 2 staff and an unknown number of residents. Findings include:	K 0920	No residents were harmed by this cited deficiency All residents had the possibility to have been affected. The refrigerator identified was moved near the outlet and the power strip/extension cord was removed. Room 215 had an improper power strip removed during the survey and replaced with a 1363A rated power strip. The extension cord was removed	05/30/2024

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	Based on observations during a tour of the facility with the Maintenance Director and Administrator-in-Training on 05/13/24 between 12:34 p.m. and 3:10 p.m., a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in the medical records office. Based on interview at the time of record review, the Maintenance Director confirmed that the fridge was plugged into a power strip. Findings were discussed with the Maintenance Director at exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice affects approximately two residents. Findings include: Based on observation during a tour of the facility with the Maintenance Director and Administrator-in-Training on 05/13/24 between 12:34 p.m. and 3:10 p.m., resident room 215 had a power strip used to power miscellaneous electronics and a television. When observing further, it could not be determined if the power strip had a UL rating of 1363A or 6060-1. The power strip was measured to be approximately two feet from the patient's bed. Based on interview at the time of observation, the Maintenance Director acknowledged the proximity of the power strip and stated they were unaware if the power strip was a medical grade power strip. The findings were reviewed with the Maintenance Director and the Administrator during the exit		for the circulation pump located on the 200 hall. The breaker for the appliance was replaced and inspected by Final Phase Electric Contractors. Maintenance staff were educated on the electrical safety rule and use of power strips/extension cords related to high draw appliances and required fixed wire systems Exhibit E. The room inspection log will be utilized monthly to assure no such cords are used in conjunction with high draw devices. Such findings will be recorded and communicated through the QAPI committee. Desk Review Requested	

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	conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately 2 staff and an unknown number of residents. Findings include: Based on observation during a tour of the facility with the Maintenance Director and Administrator-in-Training on 05/13/24 between 12:34 p.m. and 3:10 p.m., an extension cord was located in the mechanical room across from the Director of Nursing Services (DNS) office. The extension cord was being used to power a circulating pump for the water heater. Based on interview at the time of observation, the Maintenance Director confirmed that the circulating pump had been replaced but kept tripping a breaker circuit, so the cord was moved across the room. The finding was reviewed with the Maintenance Director and the Administrator-in-Training during the exit conference. 3.1-19(b)			
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5,			

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	Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room where oxygen transferring takes place, was provided with properly working mechanical ventilation. NFPA 99 2012 edition, 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical exhaust to maintain a negative pressure in the space continuously. This deficient practice could affect approximately 20 residents and staff. Findings include: Based on observation during a tour of the facility the Maintenance Director and Administrator-in-Training on 05/13/24 between 3:10 p.m., the oxygen/transfilling storage room had a mechanical vent fan installed, however did not work when tested. Based on interview at the time of observation, the Maintenance Director acknowledged that the fan appeared to not be working when tested with a sheet of paper. Findings were reviewed with the Administrator-in-Training and Maintenance Director at exit conference. 3.1-19(b)	K 0927	No resident were harmed by this cited deficiency All residents had the potential of harm should an incident have occurred. The nonfunctioning exhaust fan was replaced in the oxygen trans-fill room. The Maintenance staff were inserviced on the inspection of the room to include the working exhaust fan Exhibit E. Such inspections will be documented and maintained in the maintenance department. Any nonworking exhaust fan in the oxygen trans-fill room will be immediately reported to the Executive Director/designee for immediate remedy and recorded in the TELS work flow management system. The TELS work flow management report will be communicated through the monthly QAPI committee, Desk Review Requested	05/30/2024