STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155133	A. BUILDING -- B. WING	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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: 10/15/24 Facility Number: 000058 Provider Number: 155133 AIM Number: 100283340 At this Emergency Preparedness survey, The Belmont Health and Rehabilitation was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 180 certified beds. At the time of the survey, the census was 117. Quality Review completed on 10/21/24	E 0000	Submission of this plan of correction does not constitute admissions or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements 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	E 0039	1 No residents, staff, or visitors were affected. 2 All residents, staff, and visitors have the potential to be affected, thus the following	11/08/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Tyler Reed | Administrator | 11/08/2024

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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	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 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: During record review on 10/15/2024 between 11:00 AM and 2:30 PM with the Maintenance Director and Director of Admissions, the facility had not completed a full-scale community-based exercise. The facility provided documentation in the form of an email thread in which the facility administrator		corrective actions have been taken; the facility has conducted at least 2 full scale facility based functional exercises, that have been developed to test the Emergency Preparedness Plans. 3 The Administrator and Director of Maintenance have been re-educated (See Attachment A) to ensure facility understanding of the regulation requiring at least 2 Emergency Preparedness exercises each year. The in-service focused on Community based and full-scale facility based functional exercises, in addition to the regulation of conducting at least 2 each year. The full-scale facility based functional exercise is Attachment B. 4 The Administrator and Director of Maintenance will meet with the IDT team monthly at the Quality Assessment Committee to discuss upcoming community drills and/or facility based functional exercises to ensure the facility remains in compliance with the EP testing requirements. 5 Corrective action will be completed on or before November 8, 2024.	

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	155133	A. BUILDING -- B. WING	10/15/2024

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	reached out to a local government official and had not received a response. Based on interview at the time of record review, the Director of Admissions stated the facility had not conducted a full-scale community-based exercise. This finding was reviewed with the Maintenance Director and Director of Admissions at the exit conference.			
K 0000 Bldg. 02	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: 10/15/24 Facility Number: 000058 Provider Number: 155133 AIM Number: 100283340 At this Life Safety Code survey, The Belmont Health and Rehabilitation 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 18, New Health Care Occupancies and with 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the building electrical system with battery backup installed in all resident sleeping	K 0000	Submission of this plan of correction does not constitute admissions or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact	

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	rooms. The facility has a capacity of 180 and had a census of 117 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered including the detached laundry building. The facility has one detached oxygen storage shed which was not sprinklered. Quality Review completed on 10/21/24		me.	
K 0100 Bldg. 02	NFPA 101 General Requirements - Other Based on observation and interview, the facility failed to maintain a self-closing device on 1 of 1 North IT rooms, 1 of 1 north salons, 1 of 1 maintenance offices, 2 of 2 main therapy doors, and 1 of 1 clock-in (time clock) rooms by employee parking lot per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect at least 15 staff, residents, and visitors. Findings include: Based on observation during a tour of the facility on 10/15/2024 between 2:30 PM and 6:15 PM with the Maintenance Director and Director of Admissions, the self closing devices in the following locations were present, but disabled: a. North IT room b. North salon c. Maintenance office d. both main therapy doors e. clock-in room by employee parking lot Based on interview at the time of observation, the Maintenance Director agreed the self-closers on	K 0100	1 No residents, staff, or visitors were affected. 2 All residents, staff, and visitors have the potential to be affected, thus the following corrective actions have been taken; 3 The Maintenance Director applied and maintained the self closer for North IT Room (Attachment C) and removed self-closers on doors for the following rooms: North salon, Maintenance office, both main therapy doors, clock-in room by employee parking lot. See attachments D,E,F,G respectively. 4 The Maintenance Director and Administrator have ensured self-closers are maintained or removed for all doors that fit criteria per state regulation and life safety code. Maintenance director has been educated. See Attachment H. 5 Corrective action will be	11/02/2024

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	the doors in the aforementioned locations had been disabled. During the observation at the main therapy doors, a staff member walked by and stated "you better not make us put those closers back." This finding was reviewed with the Maintenance Director and Director of Admissions at the exit conference. 3.1-19(b)		completed on or before November 2, 2024.	
K 0324 Bldg. 02	NFPA 101 Cooking Facilities 1. Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or	K 0324	1 No residents, staff, or visitors were affected. 2 All residents, staff, and visitors have the potential to be affected, thus the following corrective actions have been taken; 3 Hood cleaning in the kitchen is completed every 6 months at The Belmont. Document obtained of last cleaning completed October 9, 2024. See Attachment I. 4 Administrator or Maintenance Director will ensure hood cleaning is performed every 6 months and documentation reflection is obtained. Maintenance Director educated. See Attachment J. 5 Corrective action will be completed on or before November 2, 2024. 1 All dietary staff have been educated on procedure of utilizing	11/12/2024

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	oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect at least 20 residents in the dining room and kitchen staff. Findings include: Based on record review with the Director of Admissions and the Maintenance Director on 10/15/2024 between 11:00 AM and 2:30 PM, no documentation for a hood cleaning was available for the 6 months prior to April 2024. Based on interview at the time of observation, the Maintenance Director stated the hood cleaning company comes once a year. This finding was reviewed with the Maintenance Director and Director of Admissions at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood fire suppression system in 1 of 1 kitchens. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 10.5.7 states instruction shall be provided to employees regarding the proper use of portable fire extinguishers and the manual activation of fire-extinguishing equipment. Section 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be		hood fire suppression system in the event of a fire under the hood. See Attachment K. 2 Administrator or Maintenance Director will ensure education is provided to dietary staff members upon hire and quarterly thereafter. Corrective action will be completed on or before November 2, 2024. 1 Stove/oven combinations in North Activity Room, South Activity Room, and Therapy are now equipped with their own disconnects in located in the same room as the stove/oven combination itself. See Attachments L, M, N. Timers for the switch that do not exceed 120 minute capacity that automatically deactivate the cook top or range, independent of staff action have been ordered and will be applied the same day we receive them. See Attachment R1. 2 Administrator or Maintenance Director will ensure disconnects are in good shape and functioning properly on a monthly basis (Attachment Nn). Maintenance Director educated. See Attachment O. Corrective action will be completed on or before November 12, 2024.	

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	reviewed with employees by management. This deficient practice could affect kitchen staff. Findings include: Based on observation with the Maintenance Director and Director of Admissions on 10/15/2024 between 2:30 PM and 6:15 PM, the kitchen was provided with a UL 300 hood system. Based on interview, kitchen staff was asked what they would do if there was a fire underneath the hood. Staff was not able to identify the steps needed to be completed to contain or eliminate a fire under the kitchen hood. This finding was reviewed with the Maintenance Director and Director of Admissions at the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure staff had access to the shutoff switch for the south activities room, north activities room, and therapy room for the stove/oven combination appliance in each of these locations. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met.			

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	19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. (c) The switch is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. This deficient practice could impact at least 10 residents and staff. Findings include: During a tour of the facility with the Maintenance Director and Director of Admissions on 10/15/2024 between 2:30 PM and 6:15 PM, the south activities room was equipped with a stove/oven combination, the north activities room was equipped with a stove/oven combination, and therapy was equipped with a stove/oven combination. Each stove/oven combination had its own disconnect. The disconnect for each stove/oven combination was not located in the same room as the stove/oven combination. Based on interview at the time of observation, the Maintenance Director stated the disconnect for the stove/oven combinations in the aforementioned locations were located in different rooms than the appliances. The finding was reviewed with the Maintenance Director and Director of Admissions at the exit conference. 3.1-19(b)			

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K 0351 Bldg. 02	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 1 kitchen freezers in accordance with LSC 18.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in Section 8.5.5.2 and Section 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect at least 5 kitchen staff. Findings include: Based on observation with the Maintenance Director and Director of Admissions on 10/15/24 between 2:30 PM and 6:15 PM, storage in the kitchen freezer was 0 inches from the sprinkler head. Based on interview at the time of the observation, the Maintenance Director agreed there was storage 0 inches from the sprinkler head in the kitchen freezer. This finding was reviewed with the Maintenance Director and Director of Admissions at the exit conference. 3.1-19(b)	K 0351	1 No residents, staff, or visitors were affected. 2 All residents, staff, and visitors have the potential to be affected, thus the following corrective actions have been taken; 3 Items that were 18 inches or less below the sprinkler deflector were moved to another location. Kitchen staff have been re-educated about storage/items not being 18 inches or less below the sprinkler deflector. See Attachment P. 4 Administrator or Maintenance Director will ensure kitchen staff is educated upon hire and quarterly thereafter. 5 Corrective action will be completed on or before November 2, 2024.	11/02/2024
K 0353 Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing			

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	1. Based on record review and interview, the facility failed to ensure 1 of 1 private fire hydrant was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2011 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Table 7.1.1.2 requires wet and dry barrel hydrants to be inspected annually and after each operation. This deficient practice affects all residents in the facility. Findings include: Based on record review on 10/15/2024 between 11:00 AM and 2:30 PM with the Director of Admissions and Maintenance Director, no documentation regarding annual fire hydrant testing was available for review for the last 12 months. Based on interview at the time of record review, the Maintenance Director stated the contractor had tested and inspected the hydrant on 10/14/24 but the facility had not received the report. The Maintenance Director attempted to obtain the records, but was unable to do so prior to the end of the survey. This finding was reviewed with the Maintenance Director and Director of Admissions at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 wound care nurse's office. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and	K 0353	1 No residents, staff, or visitors were affected. 2 All residents, staff, and visitors have the potential to be affected, thus the following corrective actions have been taken; 3 Documentation for annual fire hydrant testing has been obtained. See Attachment Q. 4 Administrator or Maintenance Director will ensure fire hydrant testing is completed and documentation obtained each year. Maintenance Director educated. See Attachment R. 5 Corrective action will be completed on or before November 2, 2024. 1 Maintenance Director fixed sprinkler head so that it was not dropped down. See Attachment S. 2 Administrator or Maintenance Director will ensure all sprinkler heads are in good condition and in the correct position monthly. See Attachment T. Maintenance Director Educated. See Attachment U. 3 Corrective action will be completed on or before November 2, 2024.	11/02/2024

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	cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect at least 1 staff in the aforementioned area Findings include: Based on observation during a tour of the facility with the Maintenance Director and Director of Admissions on 10/15/24 between 2:30 PM and 6:15 PM, the sprinkler head was observed to have dropped down resulting in a 0.5 inch gap. Based on interview at the time of observation, the Maintenance Director agreed the sprinkler in the aforementioned location had dropped down and provided the measurement. This finding was reviewed with the Maintenance Director and Director of Admissions at the exit conference. 3.1-19(b)			
K 0363 Bldg. 02	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure the egress doors at the end of the 200 and 300 halls, 1 of 1 right side of kitchen doors, and the door to room 710 were able to latch into the frame. This deficient practice could affect at least 10 residents, staff, and visitors. Findings include: Based on observation during a tour of the facility on 10/15/24 between 11:45 AM and 2:30 PM with	K 0363	1 No residents, staff, or visitors were affected. 2 All residents, staff, and visitors have the potential to be affected, thus the following corrective actions have been taken; 3 Doors were fixed so that they latched into their frames on their own for the following doors: egress doors at the end of	11/02/2024

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	the Maintenance Director and Director of Admissions, the egress doors at the end of the hallways in the 200 and 300 hallways, the door to room 710, and the door on the right side of the kitchen going into the dining room was not able to latch into the frame . Based on interview at the time of the observations, the Maintenance Director agreed the doors in the aforementioned locations did not latch into the frames fully on their own. This finding was reviewed with the Maintenance Director and Director of Admissions at the exit conference. 3.1-19(b)		hallways in the 200 and 300 hallways, the door to room 710, and the door on the right side of the kitchen going into the dining room. 4 Administrator or Maintenance Director will ensure all doors that fit criteria per state regulation and life safety code latch into their frames by themselves on a monthly basis. See Attachment Uu, Maintenance Director educated. See Attachment V. 5 Corrective action will be completed on or before November 2, 2024.	
K 0372 Bldg. 02	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure the penetrations through 1 of 1 100 hall smoke barrier walls, 1 of 1 500 hall smoke barrier walls, 1 of 1 700 hall smoke barrier walls, 1 of 1 800 hall barrier walls, and 1 of 1 600 hall barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 18.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect at least 20 staff, residents, and visitors in this smoke compartment. Findings include: Based on observation during a tour of the facility on 10/15/2024 between 2:30 PM and 6:15 PM with the Maintenance Director and Director of Admissions, the following was found in the	K 0372	1 No residents, staff, or visitors were affected. 2 All residents, staff, and visitors have the potential to be affected, thus the following corrective actions have been taken; 3 Barrier walls above ceiling tiles were fixed in the following areas: 100 hall barrier wall, 500 hall barrier wall on the nurse's station side and 500 hall barrier wall on the resident side around an orange pipe and 500 hall barrier wall on the resident side around a red wire, 600 hall barrier wall around the black pipe, all 5 penetrations on the 700 hall barrier wall on the resident side, on the	11/02/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 02 B. WING	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

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	barrier walls above the ceiling tiles: a. a 0.5 inch penetration in the 100 hall barrier wall b. a 0.5 inch penetration in the 500 hall barrier wall on the nurse's station side around the black pipe next to the orange pipe c. a 0.25 inch penetration in the 500 hall barrier wall on the resident side around the orange pipe d. a 0.75 inch penetration in the 500 hall barrier wall on the resident side around a red wire e. 5 penetrations of 1 inch each on the 700 hall barrier wall on the resident side f. a 0.25 inch penetration on the 800 hall barrier wall around the black pipe farthest from the orange pipe g. a 0.25 inch penetration on the 600 hall barrier wall around the black pipe closest to the orange pipe Based on interview at the time of the observations, the Maintenance Director agreed there were penetrations in the aforementioned locations and provided the measurements. This finding was reviewed with the Maintenance Director and the Director of Admissions at the exit conference. 3.1-19(b)		800 hall barrier wall around the black pipe. See Attachments W, X, Y, Z, Aa respectively. Maintenance Director educated. See Attachment Bb. 4 Administrator or Maintenance Director will ensure there are no penetration points in any hall barrier walls on a monthly basis. See Attachment Cc. Maintenance Director educated (Attachment Dd). 5 Corrective action will be completed on or before November 2, 2024.	
K 0741 Bldg. 02	NFPA 101 Smoking Regulations Based on record review, observation and interview, the facility failed to enforce their non-smoking policy. This deficient practice could affect at least 2 visitors outside the breakroom of the facility. Findings include: Based on record review on 10/15/2024 between	K 0741	1 No residents, staff, or visitors were affected. 2 All residents, staff, and visitors have the potential to be affected, thus the following corrective actions have been taken; 3 Non-smoking signage has been increased. See Attachments	11/02/2024

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	155133	A. BUILDING 02 B. WING	10/15/2024

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	11:00 AM and 2:15 PM with the Maintenance Director and Director of Admissions, the facility has a written policy prohibiting smoking anywhere on the premises. Based on observations during a tour of the facility on 10/15/2024 between 2:15 PM and 6:15 PM, 2 visitors were observed to be smoking in the North canopy area. The facility did have signage indicating the facility is non-smoking. Based on interview at the time of observation, the Maintenance Director confirmed the no smoking policy and notified the visitors the facility did not permit smoking. The visitors stated they would go to their car. This finding was reviewed with the Maintenance Director and Director of Admissions at the exit conference. 3.1-19(b)		Ee. 4 Admissions Director will cover non-smoking policy in-depth to family members and residents upon admission. Admissions department has been educated. See attachment Ff. Corrective action will be completed on or before November 2, 2024	
K 0918 Bldg. 02	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for the facility's diesel powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include:	K 0918	1 No residents, staff, or visitors were affected. 2 All residents, staff, and visitors have the potential to be affected, thus the following corrective actions have been taken; 3 Annual fuel quality test meeting ASTM standards was completed on November 6, 2024. Results from testing take approximately one week to receive. See attachment R3. 4 Administrator or Maintenance Director will ensure annual fuel quality test meeting ASTM standards is completed	11/06/2024

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	Based on record review with the Maintenance Director and the Director of Admissions on 10/15/2024 between 11:00 AM and 2:30 PM, no documentation for a fuel quality test that met the ASTM standards was available for review. Based on interview at the time of record review, the Maintenance Director stated he uses Diesel Mechanic in a Bottle Diesel Fuel Tester. Based on review of the documentation in the kit, the item did not appear to meet ASTM standards This finding was reviewed with the Director of Admissions and Maintenance Director at the exit conference 3.1-19(b)		annually and that documentation is obtained. Education to Maintenance Director has been completed. See Attachment Hh. 5 Corrective action will be completed on or before November 6, 2024.	
K 0930 Bldg. 02	NFPA 101 Gas Equipment - Liquid Oxygen Equipment Based on observation and interview, the facility failed to protect rooms 311, 204, 210, 704, 708, 607, 511, and 402 from the use of liquid oxygen cylinders stored in a patient bed location or patient care room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.7.4 states the maximum total quantity of liquid oxygen permitted in storage and in use in a patient bed location or patient care room shall be 120 L (31.6 gallons), provided that the patient bed location or patient care room, or both, are separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour in accordance with the adopted building code. Per Centers for Medicare & Medicaid Services (CMS), this practice is deficient according to NFPA 99, 2012 Edition, Section 11.7.4. LSC 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing	K 0930	1 No residents, staff, or visitors were affected. 2 All residents, staff, and visitors have the potential to be affected, thus the following corrective actions have been taken; 3 Liquid oxygen has been removed from all areas/room inside the building while not in use. Respiratory staff and nursing staff have been educated on where liquid oxygen should be stored when not in use. See Attachment Iil. Resident in room 511 has a doctor's order for oxygen use. Staff has been educated to ensure frequent checks to ensure oxygen is on and if removed, then staff will	11/08/2024

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	or automatic-closing. This deficient practice could affect staff and at least 16 residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Director of Admissions on 10/15/2024 between 2:30 PM and 6:15 PM, liquid oxygen containers on wheels were located in the following resident rooms 311, 204, 210, 704, 708, 607, 511, and 402. In 7 of the 8 locations, the liquid oxygen containers were not in use. In room 511, the oxygen container was observed to be on, but the resident was not wearing the cannula. At the time of this observation, the resident stated she removed the cannula when staff leaves after starting the oxygen. Based on interview at the time of observation, the Director of Admissions and Maintenance Director stated some insurance carriers will not cover oxygen concentrators but do cover liquid oxygen and that may be why some of the residents are using liquid oxygen containers. This finding was reviewed with the Maintenance Director and Director of Admissions at the exit conference. 3.1-19(b)		submit Behavior Memo Communication forms to management and then will be evaluated by facility doctor for potential d/c of oxygen if not needed. See Attachment R4. 4 Administrator or Maintenance Director will ensure oxygen is stored correctly and according to state regulation and life safety code on a monthly basis. See Attachment Jj. 5 Corrective action will be completed on or before November 8, 2024.	