| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155086 | A. BUILDING -- B. WING | 12/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| WOODLAND MANOR | 343 S NAPPANEE ST ELKHART, IN 46514 |

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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 12/23/24<br><br>Facility Number: 000034<br>Provider Number: 155086<br>AIM Number: 100274880<br><br>At this Emergency Preparedness survey, Woodland Manor was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.<br><br>The facility has 80 certified beds. At the time of the survey, the census was 69.<br><br>Quality Review completed on 12/27/24 | E 0000 | | |
| E 0004<br>SS=F<br>Bldg. -- | 403.748(a), 416.54(a), 418.113(a), 441.1<br>Develop EP Plan, Review and Update Annually<br>Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review and interview with the Maintenance Director from 9:16 a.m. to 12:32 p.m. on 12/23/24, no documentation could be found to show the EPP was reviewed and updated within | E 0004 | *The corrective action taken for those residents found to be affected by the deficient practice include:*<br>Emergency Preparedness Policies and Procedures were reviewed January 3, 2025.<br>*Other residents that have the potential to be affected have been identified by:*<br>All residents have the potential to be affected.<br>*The measures of systemic* | 01/22/2025 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Chris Chalman | Interim Administrator | 01/14/2025 |

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| | the last year. Based on interview during record review, the Maintenance Director stated the previous Administrator reviewed the EPP within the last year; however, no documentation was available showing a review or update had been completed.<br><br>This finding was reviewed with the Interim Administrator and Maintenance Director at the exit conference. | | *changes that have been put into place to ensure that the deficient practice does not recur include:*<br>The administrator calendar has a schedule in place to review Emergency Preparedness Policies every January.<br>*The corrective action taken to monitor the performance to assure compliance through quality assurance is:*<br>The Emergency Preparedness Binder will be reviewed monthly in QAPI x6 months to assure all systems are in place. | |
| E 0007 SS=F Bldg. -- | 403.748(a)(3), 416.54(a)(3), 418.113(a)(<br>EP Program Patient Population<br><br>Based on record review and interview, the facility failed to ensure the emergency preparedness plan addressed resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans in accordance with 42 CFR 483.73(a)(3). This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review and interview with the Maintenance Director from 9:16 a.m. to 12:32 p.m. on 12/23/24, the Emergency Preparedness Plan (EPP) failed to address persons at-risk or the type of services the LTC facility has the ability to provide in an emergency. Based on interview during record review, the Maintenance Director stated a contracted individual had started to | E 0007 | *The corrective action taken for those residents found to be affected by the deficient practice include:*<br>A Resident Evacuation Assessment was completed in January, 2025<br>*Other residents that have the potential to be affected have been identified by:*<br>All residents have the potential to be affected.<br>*The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:*<br>The Resident Evacuation Assessment will be reviewed annually.<br>*The corrective action taken to monitor the performance to assure* | 01/22/2025 |

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| | review and update the Emergency Preparedness Plan (EPP); however, the review and update was not completed and the EPP was missing policies and procedures. The Maintenance Director also stated he was in the process of reviewing and updating the EPP.<br><br>This finding was reviewed with the Interim Administrator and Maintenance Director at the exit conference. | | *compliance through quality assurance is:*<br>The Emergency Preparedness Binder will be reviewed monthly in QAPI x6 months to assure all systems are in place. | |
| E 0013 SS=F Bldg. -- | 403.748(b), 416.54(b), 418.113(b), 441.1<br>Development of EP Policies and Procedures<br><br>Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(b). The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review and interview with the Maintenance Director from 9:16 a.m. to 12:32 p.m. on 12/23/24, no documentation could be found to show the EPP Policies and Procedures were reviewed and updated within the last year. Based on interview during record review, the Maintenance Director stated the previous Administrator reviewed the EPP within the last year; however, no documentation was available | E 0013 | *The corrective action taken for those residents found to be affected by the deficient practice include:*<br>The Emergency Preparedness binder has a Disaster Policy and Procedure updated January 2025.<br>*Other residents that have the potential to be affected have been identified by:*<br>All residents have the potential to be affected.<br>*The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:*<br>The Disaster Policy and Procedure will be reviewed annually.<br>*The corrective action taken to monitor the performance to assure compliance through quality assurance is:*<br>The Emergency Preparedness Binder will be reviewed monthly in QAPI x6 months to assure all | 01/22/2025 |

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| | showing a review or update had been completed.<br><br>This finding was reviewed with the Interim Administrator and Maintenance Director at the exit conference. | | systems are in place. | |
| E 0018 SS=F Bldg. -- | 403.748(b)(2), 416.54(b)(1), 418.113(b)( Procedures for Tracking of Staff and Patients<br><br>Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures included a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b) (2). This deficient practice could affect all residents and staff.<br><br>Findings include:<br><br>Based on record review and interview with the Maintenance Director from 9:16 a.m. to 12:32 p.m. on 12/23/24, no policies and procedures that include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency was available for review. Based on interview during record review, the Maintenance Director stated a contracted individual had started to review and update the Emergency Preparedness Plan (EPP); however, the review and update was not completed and the EPP was missing policies and procedures. The Maintenance Director also stated he was in the process of reviewing and updating the EPP. | E 0018 | *The corrective action taken for those residents found to be affected by the deficient practice include:*<br>The facility has a form entitled Resident Evacuation Checklist that will be used in the event of an evacuation.<br>*Other residents that have the potential to be affected have been identified by:*<br>All residents have the potential to be affected.<br>*The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:*<br>The Resident Evacuation Checklist is readily available in the Emergency Preparedness Binder and will be used in the event of an evacuation.<br>*The corrective action taken to monitor the performance to assure compliance through quality assurance is:*<br>The Emergency Preparedness Binder will be reviewed monthly in QAPI x6 months to assure all systems are in place. | 01/22/2025 |

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| | This finding was reviewed with the Interim Administrator and Maintenance Director at the exit conference. | | | |
| E 0029 SS=F Bldg. -- | 403.748(c), 416.54(c), 418.113(c), 441.1 Development of Communication Plan<br><br>Based on record review and interview, the facility failed to review and update the Emergency Preparedness Communication Plan at least annually in accordance with 42 CFR 483.73(c). The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually for LTC facilities. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review and interview with the Maintenance Director from 9:16 a.m. to 12:32 p.m. on 12/23/24, no documentation could be found to show the Emergency Preparedness Communication Plan was reviewed and updated within the last year. Based on interview during record review, the Maintenance Director stated the previous Administrator reviewed the EPP within the last year; however, no documentation was available showing a review or update had been completed.<br><br>This finding was reviewed with the Interim Administrator and Maintenance Director at the exit conference. | E 0029 | *The corrective action taken for those residents found to be affected by the deficient practice include:*<br>The facility has in place an Emergency Communication Policy and Procedure reviewed January, 2025.<br>*Other residents that have the potential to be affected have been identified by:*<br>All residents have the potential to be affected.<br>*The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:*<br>The Emergency Communication Policy and Procedure will be reviewed annually.<br>*The corrective action taken to monitor the performance to assure compliance through quality assurance is:*<br>The Emergency Preparedness Binder will be reviewed monthly in QAPI x6 months to assure all systems are in place. | 01/22/2025 |
| E 0032 SS=F Bldg. -- | 403.748(c)(3), 416.54(c)(3), 418.113(c)( Primary/Alternate Means for Communication<br><br>Based on record review and interview, the | E 0032 | *The corrective action taken for* | 01/22/2025 |

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| | facility's Emergency Preparedness Communications Plan failed to address primary and alternate means of communication in accordance with 42 CFR 483.73(c)(3). The facility's Emergency Preparedness Communications Plan must include: (3) Primary and alternate means for communicating with the following:<br>(i) [Facility] staff.<br>(ii) Federal, State, tribal, regional, and local emergency management agencies.<br>This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review and interview with the Maintenance Director from 9:16 a.m. to 12:32 p.m. on 12/23/24, the Emergency Preparedness Communications Plan did not address primary and alternate means of communication. Based on interview during record review, the Maintenance Director stated a contracted individual had started to review and update the Emergency Preparedness Plan (EPP); however, the review and update was not completed and the EPP was missing policies and procedures. The Maintenance Director also stated he was in the process of reviewing and updating the EPP including the Communication Plan.<br><br>This finding was reviewed with the Interim Administrator and Maintenance Director at the exit conference. | | *those residents found to be affected by the deficient practice include:*<br>The facility has in place an Emergency Communication Policy and Procedure which includes primary and alternate means of communication. The policy was reviewed January, 2025.<br>*Other residents that have the potential to be affected have been identified by:*<br>All residents have the potential to be affected.<br>*The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:*<br>The Emergency Communication Policy and Procedure will be reviewed annually.<br>*The corrective action taken to monitor the performance to assure compliance through quality assurance is:*<br>The Emergency Preparedness Binder will be reviewed monthly in QAPI x6 months to assure all systems are in place. | |
| E 0035 SS=F Bldg. -- | 483.475(c)(8), 483.73(c)(8)<br>LTC and ICF/IID Sharing Plan with Patients<br><br>Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing | E 0035 | *The corrective action taken for those residents found to be affected by the deficient practice* | 01/22/2025 |

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| | information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73(c)(8).<br>This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review and interview with the Maintenance Director from 9:16 a.m. to 12:32 p.m. on 12/23/24, the Emergency Preparedness Communications Plan failed to include a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). Based on interview during record review, the Maintenance Director stated a contracted individual had started to review and update the Emergency Preparedness Plan (EPP); however, the review and update was not completed and the EPP was missing policies and procedures. The Maintenance Director also stated he was in the process of reviewing and updating the EPP including the Communication Plan.<br><br>This finding was reviewed with the Interim Administrator and Maintenance Director at the exit conference. | | *include:*<br>A letter from the facility about the Emergency Preparedness Plan has been sent to residents and family members.<br>*Other residents that have the potential to be affected have been identified by:*<br>All residents have the potential to be affected.<br>*The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:*<br>The Administrator has set up a system to review the Emergency Preparedness Binder regularly.<br>*The corrective action taken to monitor the performance to assure compliance through quality assurance is:*<br>The Emergency Preparedness Binder will be reviewed monthly in QAPI x6 months to assure all systems are in place. | |
| E 0036 SS=F Bldg. -- | 403.748(d), 416.54(d), 418.113(d), 441.1<br>EP Training and Testing<br><br>Based on record review and interview, the facility failed to review and update the Emergency Preparedness Training and Testing Program at least annually in accordance with 42 CFR 483.73(d). The LTC facility must develop and maintain an emergency preparedness training and | E 0036 | *The corrective action taken for those residents found to be affected by the deficient practice include:*<br>The facility has a policy in place for Exercise, Drills and | 01/22/2025 |

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| | testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review and interview with the Maintenance Director from 9:16 a.m. to 12:32 p.m. on 12/23/24, no documentation could be found to show the Emergency Preparedness Testing and Training Program was reviewed and updated within the last year. Based on interview during record review, the Maintenance Director stated the previous Administrator reviewed the EPP within the last year; however, no documentation was available showing a review or update had been completed.<br><br>This finding was reviewed with the Interim Administrator and Maintenance Director at the exit conference. | | Simulations related to Disaster Preparedness. It was reviewed January, 2025.<br>*Other residents that have the potential to be affected have been identified by:*<br>All residents have the potential to be affected.<br>*The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:*<br>The Policy and Procedure for Exercise, Drills and Simulations will be reviewed annually.<br>*The corrective action taken to monitor the performance to assure compliance through quality assurance is:*<br>The Emergency Preparedness Binder will be reviewed monthly in QAPI x6 months to assure all systems are in place. | |
| E 0037 SS=F Bldg. -- | 403.748(d)(1), 416.54(d)(1), 418.113(d)(<br>EP Training Program<br><br>Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following:<br>(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; | E 0037 | *The corrective action taken for those residents found to be affected by the deficient practice include:*<br>All current staff members have received training on the Emergency Preparedness Plan.<br>*Other residents that have the potential to be affected have been* | 01/22/2025 |

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| | (ii) Provide emergency preparedness training at least annually;<br>(iii) Maintain documentation of all emergency preparedness training;<br>(iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d)(1).<br>This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review and interview with the Maintenance Director from 9:16 a.m. to 12:32 p.m. on 12/23/24, no documentation of annual EPP training and no documentation to show staff could demonstrate knowledge of the EPP was available for review. Based on an interview at the time of records review, the Maintenance Director stated EPP training had not been conducted since he started his employment approximately seven months ago. The Maintenance Director also stated he was not aware of any other documentation to show EPP training had been conducted in the last 12 months.<br><br>This finding was reviewed with the Interim Administrator and Maintenance Director at the exit conference. | | *identified by:*<br>All residents have the potential to be affected.<br>*The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:*<br>Emergency Preparedness training has been added to general orientation for all new employees.<br>*The corrective action taken to monitor the performance to assure compliance through quality assurance is:*<br>The Administrator/designee will audit employee files to ensure staff have received training on the Emergency Preparedness system. Audits will be conducted 1x per month x6 months. The results of these audits will be reviewed in the monthly QAPI meeting. | |
| E 0039 SS=F Bldg. -- | 403.748(d)(2), 416.54(d)(2), 418.113(d)(<br>EP Testing Requirements<br><br>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 | E 0039 | *The corrective action taken for those residents found to be affected by the deficient practice include:*<br>A tornado drill was completed at the facility on December 27, 2024.<br>*Other residents that have the* | 01/26/2025 |

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| | a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.<br>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.<br>(ii) Conduct an additional exercise that may include, but is not limited to the following:<br>a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.<br>b. A mock disaster drill; or<br>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.<br>(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).<br>This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review and interview with the Maintenance Director from 9:16 a.m. to 12:32 p.m. on 12/23/24, the facility was able to provide documentation of a Table-Top exercise with a Cyber-Security scenario that was conducted on 09/11/2024; however, the facility was not able to provide documentation of a full-scale exercise. At time of record review the Maintenance Director | | *potential to be affected have been identified by:*<br>All residents have the potential to be affected.<br>*The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:*<br>The Maintenance Director will schedule a full-scale exercise at least one time annually going forward.<br>*The corrective action taken to monitor the performance to assure compliance through quality assurance is:*<br>The Emergency Preparedness Binder will be reviewed monthly in QAPI x6 months to assure all systems are in place. | |

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| | stated no other exercises were conducted.<br><br>This finding was reviewed with the Interim Administrator and Maintenance Director at the exit conference. | | | |
| K 0000<br><br>Bldg. 01 | A Life Safety Code (LSC) Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 12/23/24<br><br>Facility Number: 000034<br>Provider Number: 155086<br>AIM Number: 100274880<br><br>At this LSC survey, Woodland Manor 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.<br><br>This one-story facility was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and areas open to the corridor and battery-operated smoke detectors in the resident rooms. The building is partially protected by a Type II EES 33 kW diesel-powered emergency generator.<br><br>The facility has a capacity of 80 and had a census of 69 at the time of this survey. | K 0000 | | |

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|---|---|---|---|
| | 155086 | A. BUILDING 01<br>B. WING | 12/23/2024 |

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| | Quality Review completed on 12/27/24 | | | |
| K 0321 SS=E Bldg. 01 | NFPA 101<br>Hazardous Areas - Enclosure<br><br>Based on observation and interview, the facility failed to ensure the Central Supply Storage room that was determined to be a hazardous area was separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with LSC 7.2.1.8. This deficient practice could affect residents, staff and visitors in 1 of 6 smoke compartments.<br><br>Findings include:<br><br>Based on observation and interview with the Maintenance Director from 12:32 p.m. to 1:55 p.m. on 12/23/24, the corridor door to the Central Supply Storage room was equipped with a self-closing device but the door failed to fully close and latch into the door frame when tested more than three separate times. Based on interview at the time of observation, the Maintenance Director stated he was aware the corridor door would not fully close or latch and stated the facility has " ...got someone coming out to look at it."<br><br>This finding was reviewed with the Interim Administrator and Maintenance Director at the exit conference.<br><br>3.1-19(b) | K 0321 | **What corrective actions will be accomplished to address the deficient practice?**<br>The door to central supply was fixed January 3, 2025.<br>**How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**<br>All residents have the potential to be affected by this deficiency.<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**<br>Maintenance Director will routinely check closure of doors in the facility as preventative maintenance.<br>**How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>Maintenance Director/designee will complete an audit of 10 doors per week for proper closure x4 weeks, 10 doors per month x4 months, then 10 | 01/22/2025 |

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| | | | doors x1 month. Those results will be submitted to the Administrator and included in Quality Assurance Process Improvement meeting monthly for six months. | |
| K 0324<br>SS=E<br>Bldg. 01 | NFPA 101<br>Cooking Facilities<br><br>1.) Based on record review and interview; the facility failed to ensure 1 of 1 kitchen fire suppression system was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices. Hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect kitchen staff.<br><br>Findings include:<br><br>Based on record review and interview with the Maintenance Director from 9:16 a.m. to 12:32 p.m. on 12/23/24, a document titled "Kitchen Suppression System Inspection" dated 04/16/24 indicated the kitchen fire suppression system was inspected; however, no documentation of a semiannual kitchen fire suppression system inspection six months after was available for review. Based on interview at the time of record review, the Maintenance Director stated he was not aware of a semiannual fire suppression system inspection being completed. | K 0324 | **What corrective actions will be accomplished to address the deficient practice?**<br>Commercial Fire inspected the fire suppression system and the kitchen exhaust system on August 1, 1024.<br>**How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**<br>All residents have the potential to be affected by this process.<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**<br>Maintenance Director has developed a tracking system to assure inspections are completed annually.<br>**How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put** | 01/22/2025 |

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| | 2.) Based on record review 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 oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substances. 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 kitchen staff.<br><br>Findings include:<br><br>Based on record review and interview with the Maintenance Director from 9:16 a.m. to 12:32 p.m. on 12/23/24, an un-titled document dated 02/14/24 indicated the kitchen exhaust system was | | **into place?**<br>Inspections have been completed for 2024. Two inspections are due in 2025. The Maintenance Director/designee will audit records in 2025. | |

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| | inspected; however, no documentation of a semiannual kitchen fire suppression system inspection six months after was available for review. Based on interview at the time of record review, the Maintenance Director stated he was not aware of a semiannual exhaust system inspection being completed.<br><br>These findings were reviewed with the Interim Administrator and Maintenance Director at the exit conference.<br><br>3.1-19(b) | | | |
| K 0355 SS=E Bldg. 01 | NFPA 101<br>Portable Fire Extinguishers<br><br>Based on record review, observation and interview, the facility failed to ensure 1 of 1 portable fire extinguisher in the maintenance office was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the | K 0355 | *The corrective action taken for those residents found to be affected by the deficient practice include:*<br>The fire extinguisher in the maintenance office was inspected January 3, 2025.<br>*Other residents that have the potential to be affected have been identified by:*<br>All residents have the potential to be affected.<br>*The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:*<br>All fire extinguishers are inspected monthly.<br>*The corrective action taken to monitor the performance to assure compliance through quality assurance is:*<br>Maintenance Director/designee is | 01/22/2025 |

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| | work, and identifies the name of the agency performing the work.<br>This deficient practice could affect staff in the maintenance office.<br><br>Findings include:<br><br>Based on record review and interview with the Maintenance Director from 9:16 a.m. to 12:32 p.m. on 12/23/24, documentation an annual fire extinguisher inspection had been completed on 03/26/24; however, a portable fire extinguisher located in the maintenance office had an inspection tag that was more than 1 year old. Based on interview at the time of observation, the Maintenance Director acknowledged the fire extinguisher in the maintenance office was not inspected when the annual inspection had been completed on the other fire extinguishers in the facility.<br><br>This finding was reviewed with the Interim Administrator and Maintenance Director at the exit conference.<br><br>3.1-19(b) | | responsible for ensuring fire extinguishers are completed monthly. A random audit of 5 fire extinguishers will be completed weekly x4 weeks, then monthly x4 month. Those results will be submitted to the Administrator and included in Quality Assurance Process Improvement meeting monthly for six months. | |
| K 0363 SS=E Bldg. 01 | NFPA 101<br>Corridor - Doors<br><br>Based on observation and interview, the facility failed to ensure 1 of 20 resident room corridor doors in the 100 hall 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 residents, staff and visitors in 1 of 6 smoke compartments.<br><br>Findings include: | K 0363 | *The corrective action taken for the deficient practice include:*<br>The door to room 102 has been fixed.<br>*Other residents that have the potential to be affected have been identified by:*<br>All residents on this hall have the potential to be affected.<br>*The measures of systemic* | 01/22/2025 |

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| | Based on observation and interview with the Maintenance Director from 12:32 p.m. to 1:55 p.m. on 12/23/24, resident room 102 corridor door was not able to be closed and latched. At the time of observation, the Maintenance Director attempted to close and latch the door more than three times but was unable to latch the door. Based on interview at the time of observation, the Maintenance director stated he was not able to latch the door shut and that the door would need to be adjusted.<br><br>This finding was reviewed with the Interim Administrator and Maintenance Director at the exit conference.<br><br>3.1-19(b) | | *changes that have been put into place to ensure that the deficient practice does not recur include:*<br>Door audits will be included in regular preventative maintenance.<br>*The corrective action taken to monitor the performance to assure compliance through quality assurance is:*<br>Maintenance Director/designee is responsible for ensuring all doors close properly. A random audit of 5 doors will be completed daily x4 weeks, then monthly x4 month. Those results will be submitted to the Administrator and included in Quality Assurance Process Improvement meeting monthly for six months. | |
| K 0374<br>SS=E<br>Bldg. 01 | NFPA 101<br>Subdivision of Building Spaces - Smoke Barrie<br>Based on observation and interview, the facility failed to ensure 1 of 7 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice affects residents, staff and visitors in 2 of 6 smoke compartments.<br><br>Findings include:<br><br>Based on observation and interview with the Maintenance Director from 12:32 p.m. to 1:55 p.m. on 12/23/24, the set of smoke barrier doors between the Director of Nursing office and the | K 0374 | *The corrective action taken for the deficient practice include:*<br>The smoke barrier door between the Director of Nursing office and the public restroom has been repaired.<br>*Other residents that have the potential to be affected have been identified by:*<br>All residents have the potential to be affected.<br>*The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:*<br>Door audits will be included in regular preventative maintenance. | 01/22/2025 |

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| | Public restrooms in the main hall corridor did not close completely. The door coordinator failed to function properly, leaving one door open when self-closing. Based on interview at time of observation the Maintenance Director stated the door coordinator was loose preventing the doors from closing properly.<br><br>This finding was reviewed with the Interim Administrator and Maintenance Director at the exit conference.<br><br>3.1-19(b) | | *The corrective action taken to monitor the performance to assure compliance through quality assurance is:*<br>Maintenance Director/designee is responsible for ensuring all doors close properly. A random audit of 5 doors will be completed daily x4 weeks, then monthly x4 month. Those results will be submitted to the Administrator and included in Quality Assurance Process Improvement meeting monthly for six months. | |
| K 0712<br>SS=F<br>Bldg. 01 | NFPA 101<br>Fire Drills<br><br>Based on record review and interview, the facility failed to conduct quarterly fire drills on each shift. LSC 101 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 all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review and interview with the Maintenance Director from 9:16 a.m. to 12:32 p.m. on 12/23/24, the facility failed to provide documentation of a fire drill conducted during the third shift in the second quarter of 2024. Based on interview with the Maintenance Director, he stated that he tried to follow a schedule that was provided to him by the facility's corporation. The facility provided a schedule that was dated 2023, it did not appear that the times and dates would | K 0712 | *The corrective action taken for the deficient practice include:*<br>A fire drill was completed on third shift on December 28, 2024.<br>*Other residents that have the potential to be affected have been identified by:*<br>All residents have the potential to be affected.<br>*The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:*<br>Fire drills are routinely scheduled one time per shift per quarter.<br>*The corrective action taken to monitor the performance to assure compliance through quality assurance is:*<br>Maintenance Director/designee is responsible for completing all fire drills. The Administrator/designee | 01/22/2025 |

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| | have met the requirements of quarterly fire drills on each shift. The schedule was not current, and it included other events such as tornado drills. The dates and times of the fire drills that were conducted in 2024 did not match the dates and times listed on the schedule provided. Based on interview at the time of record review the Maintenance Director acknowledged a fire drill was not conducted during the third shift in the second quarter of 2024.<br><br>This finding was reviewed with the Interim Administrator and Maintenance Director at the exit conference.<br><br>3.1-19(b)<br>3.1-51(c) | | will conduct an audit of all fire drills completed each month x6 months. Those results will be submitted to the Administrator and included in Quality Assurance Process Improvement meeting monthly for six months. | |
| K 0920 SS=E Bldg. 01 | NFPA 101<br>Electrical Equipment - Power Cords and Extens<br>Based on observation and interview, the facility failed to ensure flexible cords and adapters were not used in 2 of 6 smoke compartments as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. NFPA 99, section 3.3.139 Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice could affect residents, staff and visitors in 2 of 6 smoke | K 0920 | *The corrective action taken for the deficient practice include:*<br>The power cord and extension cord were removed from the premises.<br>*Other residents that have the potential to be affected have been identified by:*<br>All residents have the potential to be affected.<br>*The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:*<br>Education provided to residents, family members and staff regarding the policy for use of extension cords and power strips.<br>*The corrective action taken to* | 01/22/2025 |

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| | compartments.<br><br>Findings include:<br><br>Based on observation and interview with the Maintenance Director from 12:32 p.m. to 1:55 p.m. on 12/23/24, 1) A power strip of an unknown rating was found powering another power strip of unknown rating that supplied power to fish tank accessories in resident room 100. The power strips were located within the patient care vicinity. 2) An extension cord was found powering 2 electronic chargers in the Community Liaison Director's office.<br><br>These findings were reviewed with the Interim Administrator and Maintenance Supervisor at the exit conference.<br><br>3.1-19(b) | | *monitor the performance to assure compliance through quality assurance is:*<br>Maintenance Director/designee will conduct an audit for extension cords or power strips of 5 rooms or offices per day x4 weeks, then 5 rooms or offices per month x5 months Those results will be submitted to the Administrator and included in Quality Assurance Process Improvement meeting monthly for six months. | |