

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____	X3) DATE SURVEY COMPLETED 08/10/2021
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NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
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E 0000 Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 08/10/21</p> <p>Facility Number: 000569 Provider Number: 155531 AIM Number: 100267660</p> <p>At this Emergency Preparedness survey, Oakbrook Village was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 55 and had a census of 26 at the time of this survey.</p> <p>Quality Review completed on 08/17/21</p>	E 0000	<p>Envive Healthcare of Huntington Life Safety Survey Plan of Correction</p> <p>The facility requests paper compliance for these citations. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p>	
E 0037 SS=C Bldg. --	<p>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)</p> <p>EP Training Program</p> <p>§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).</p> <p>*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at</p>			

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	<p>§483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]</p> <p>(1) Training program. The [facility] must do all of the following:</p> <p>(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.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.</p> <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <p>(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.</p> <p>(ii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iii) Provide emergency preparedness training at least every 2 years.</p> <p>(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.</p> <p>(v) Maintain documentation of all emergency preparedness training.</p>				

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	<p>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:</p> <p>(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.</p> <p>(ii) After initial training, provide emergency preparedness training every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iv) Maintain documentation of all emergency preparedness training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:</p> <p>(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.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(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.</p> <p>(iv) Maintain documentation of all training.</p>			

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	<p>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.</p> <p>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:</p> <p>(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.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:</p> <p>(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.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(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.</p> <p>(v) If the emergency preparedness policies</p>			

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	<p>and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p> <p>(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.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.</p> <p>*[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.</p>	E 0037	Tag: E 037	09/03/2021

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	<p>Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program included staff training annually. 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 the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d)(1). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's "Emergency Preparedness Plan (Program) documentation with the Executive Director during record review on 08/10/21 between 10:10 a.m. and 12:45 p.m., documentation for staff training on emergency preparedness within the most recent twelve-month period was not available for review. Based on interview at the time of record review, the Executive Director stated staff training on the emergency preparedness program had not been done in the past year and documentation within the most recent twelve-month period was not available for review at the time of the survey.</p> <p>This finding was acknowledged by the Executive Director at the time of records review and again at the exit conference with the Executive Director and Maintenance Director on 08/10/21 at 3:45 p.m.</p>		<p>Scope: C</p> <p>1) Immediate actions taken for those residents identified:</p> <p>No residents were affected by the deficient practice</p> <p>2) How the facility identified other residents:</p> <p>All residents have the potential to be affected.</p> <p>3) Measures put into place/system changes:</p> <p>All staff will be re-educated on the facilities emergency preparedness policies and procedures</p> <p>4) How the corrective actions will be monitored:</p>	

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E 0039 SS=C Bldg. --	<p>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)</p> <p>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).</p> <p>*[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]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p>		<p>A process has been put in place to ensure the emergency preparedness plan is reviewed with the staff on an annual basis. The Executive Director/designee will monitor for compliance and report to the Quality Assurance Committee X2 quarters.</p> <p>5) Date of compliance: 09/03/2021</p>	

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	<p>(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 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.</p> <p>*[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</p>			
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	<p>following:</p> <p>(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 onset of the emergency event.</p> <p>(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.</p> <p>(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</p>				

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	<p>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.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(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.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]</p> <p>(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:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the</p>				

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	<p>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.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(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.</p> <p>*[For PACE at §460.84(d):]</p> <p>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(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</p>				

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	<p>individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(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:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(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.</p> <p>*[For LTC Facilities at §483.73(d):]</p> <p>(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:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>(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</p>				

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	<p>functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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 messages, or prepared questions designed to challenge an emergency plan.</p> <p>(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.</p> <p>*[For ICF/IIDs at §483.475(d):</p> <p>(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:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.</p> <p>(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.</p> <p>(ii) Conduct an additional annual exercise</p>			

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	<p>that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or</p> <p>(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.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale functional exercise under paragraph (d)(2)(i) of this section is conducted, that may</p>				

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	<p>include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.</p> <p>*[For OPOs at §486.360]</p> <p>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p> <p>(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.</p> <p>(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.</p>			

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	<p>*[RNCHIs at §403.748]:</p> <p>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:</p> <p>(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.</p> <p>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.</p> <p>Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. The ICF/IID facility must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>b. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID 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.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following:</p> <p>a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.</p> <p>b. A mock disaster drill; or</p> <p>c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion led</p>	E 0039	<p>Tag: E 039</p> <p>Scope: C</p> <p>1) Immediate actions taken for those residents identified:</p> <p>No residents were affected by the deficient practice</p> <p>2) How the facility identified other residents:</p> <p>All residents have the potential to be affected</p>	09/03/2021
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	<p>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.</p> <p>(iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's "Emergency Preparedness Plan (Program) documentation with the Executive Director during record review on 08/10/21 between 10:10 a.m. and 12:45 p.m., The COVID 19 Pandemic was being used as the full-scale exercise. However, no documentation of an additional/second exercise of choice was available for review to show the required exercise was conducted within the past 12 months. Based on interview at the time of records review, the Executive Director stated an additional exercise was not conducted within in the past 12 months.</p> <p>This finding was acknowledged by the Executive Director at the time of records review and again at the exit conference with the Executive Director and Maintenance Director on 08/10/21 at 3:45 p.m.</p>		<p>3) Measures put into place/system changes:</p> <p>An additional/second smaller scale disaster exercise of choice has been scheduled for 9/1/21</p> <p>4) How the corrective actions will be monitored:</p> <p>A process has been put in place to ensure that a smaller scale disaster exercise is scheduled on an annual basis. The Maintenance Director/designee will be responsible for scheduling this exercise and will report to the Quality Assurance Committee X2 quarters. The Executive Director sill monitor for compliance.</p> <p>5) Date of compliance: 09/03/2021</p>		

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K 0000 Bldg. 01	<p>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).</p> <p>Survey Date: 08/10/21</p> <p>Facility Number: 000569 Provider Number: 155531 AIM Number: 100267660</p> <p>At this Life Safety Code survey, Oakbrook Village 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.</p> <p>This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridor and resident rooms. The facility has a capacity of 55 and had a census of 26 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility had a detached garage providing facility services including extra resident beds, a snow blower and maintenance supplies that was not sprinklered.</p> <p>Quality Review completed on 08/17/21</p>	K 0000	<p>Envive Healthcare of Huntington Life Safety Survey Plan of Correction</p> <p>The facility requests paper compliance for these citations. <i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	
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K 0211 SS=E Bldg. 01	<p>NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 exit discharge paths that lead through courtyard was readily accessible at all times and 1 of 1 procedures on how to unlock the gate in the exit discharge path was known to all staff. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Executive Director on 08/10/21 between 1:00 p.m. and 3:10 p.m., the dining hall had a door marked EXIT which led into the fenced courtyard. The discharge exit from the fenced courtyard led to a gate before accessing the public way. The gate was not locked but displayed a padlock and chain which were being used to hold the bent and misaligned gate into place. The aforementioned chain and lock gave appearance of being locked. The Executive Director acknowledged that this could be confusing during an emergency.</p> <p>This finding was acknowledged by the Executive Director at the time of observation and again at the exit conference with the Executive Director and Maintenance Director on 08/10/21 at 3:45 p.m.</p>	K 0211	<p>Tag: K 211</p> <p>Scope: E</p> <p>1) Immediate actions taken for those residents identified:</p> <p>No residents were affected by the deficient practice</p> <p>2) How the facility identified other residents:</p> <p>All residents have the potential to be affected</p>	09/03/2021	

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	3.1-19(b)		<p>3) Measures put into place/system changes:</p> <p>The padlock on the chain at the fence to the courtyard has been removed</p> <p>4) How the corrective actions will be monitored:</p> <p>A process has been put in place to add checking the fence to the Maintenance Director's regular building rounds to ensure that the gate to the fence in the courtyard remains without a padlock ensuring this could be used as an exit to the building should an emergency situation occur. The Maintenance Director/designee will report to the Quality Assurance Committee X2 quarters. The Executive Director will monitor for compliance</p> <p>5) Date of compliance: 09/03/2021</p>	

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K 0222 SS=F Bldg. 01	<p>NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS</p>						

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	<p>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</p> <p>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</p> <p>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</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through the Main Entrance exit was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 15, staff and visitors if needing to exit the facility.</p> <p>Findings include:</p>	K 0222	<p>Tag: K 222 Scope: F</p> <p>1) Immediate actions taken for those residents identified: No residents were affected by the deficient practice</p> <p>2) How the facility identified other residents: All residents have the potential to</p>	09/03/2021

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K 0226 SS=E Bldg. 01	<p>Based on observations during a tour of the facility with the Executive Director on 08/10/21 between 1:00 p.m. and 3:10 p.m., the Main Entrance exit door, marked as a facility exit, was magnetically locked and could be opened by entering a four digit code but the code was not posted at the exit. This finding was acknowledged by the Executive Director at the time of observation and again at the exit conference with the Executive Director and Maintenance Director on 08/10/21 at 3:45 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 Horizontal Exits Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 3 horizontal exit fire door sets were arranged to automatically close and</p>	K 0226	<p>be affected</p> <p>3) Measures put into place/system changes: On 8/11/21 the keypad code was placed on the keypad</p> <p>4) How the corrective actions will be monitored: A process has been put in place to add checking that the code remains in place to the Maintenance Director's regular building rounds. The Maintenance Director will report to the Quality Assurance Committee X2 quarters. The Executive Director will monitor for compliance</p> <p>5) Date of compliance: 09/03/2021</p> <p>Tag: K 226 Scope: E</p>	09/03/2021

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	<p>latch. LSC section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. In addition NFPA 80, the Standard for Fire Doors and Other Opening Protectives, section 6.1.4.2.1 states self-closing doors shall swing easily and freely and shall be equipped with a closing device to cause the door to close and latch each time it is opened. This deficient could affect 40 residents in 2 smoke compartments when occupied.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Executive Director on 08/10/21 between 1:00 p.m. and 3:10 p.m., the 1 ½ hour rated fire door set in the 200 Hall used as a smoke barrier, when tested, failed to latch into the frame in the closed position. Based on interview at the time of observation, the Executive Director agreed that after 4 tries, the fire door set was not latching into the frame. This finding was acknowledged by the Executive Director at the time of observation and again at the exit conference with the Executive Director and Maintenance Director on 08/10/21 at 3:45 p.m.</p> <p>3.1-19(b)</p>		<p>1) Immediate actions taken for those residents identified:</p> <p>No residents were affected by the deficient practice</p> <p>2) How the facility identified other residents:</p> <p>40 residents have the potential to be affected (2 smoke compartments)</p> <p>3) Measures put into place/system changes:</p> <p>Maintenance Director adjusted the 200 Hall fire door latch to ensure appropriate closure on 8/23/21</p> <p>4) How the corrective actions will be monitored:</p> <p>A process has been put in place to check the fire doors to ensure that they are closing properly. The Maintenance Director will be responsible to check with regular building rounds. The Maintenance Director/designee will report to the Quality Assurance Committee X2 quarters and rounds to check doors will be ongoing. The Executive Director will monitor for compliance</p> <p>5) Date of compliance:</p>	

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K 0232 SS=F Bldg. 01	<p>NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING</p> <p>The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5</p> <p>Based on observation, the facility failed to meet the clear width requirement for 2 of 4 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met:</p> <p>(a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by LSC 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in LSC 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance</p>	K 0232	<p>09/03/2021</p> <p>Tag: K 232 Scope: F</p> <p>1) Immediate actions taken for those residents identified: No residents were affected by the deficient practice</p> <p>2) How the facility identified other residents: All residents have the potential to be affected</p> <p>3) Measures put into place/system changes: Furniture has been removed from 200 Hall corridor by nurses station. Service corridor has been cleared and staff will be</p>	09/03/2021

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	<p>with LSC 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space.</p> <p>(h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with LSC 19.3.5.8</p> <p>This deficient practice could affect all residents, staff and visitors exiting the facilities main entrance or if needing to exit through the Service Hallway.</p> <p>Findings:</p> <p>1) Based on observations during a tour of the facility with the Executive Director on 08/10/21 between 1:00 p.m. and 3:10 p.m., the 200 Hall corridor near the Nurses Station contained two chairs extending into the corridor more than 24 inches. The aforementioned chairs were free standing, not affixed to the wall or floor. This finding was acknowledged by the Executive Director at the time of observation and again at the exit conference with the Executive Director and Maintenance Director on 08/10/21 at 3:45 p.m.</p> <p>2) Based on observations during a tour of the facility with the Executive Director on 08/10/21 between 1:00 p.m. and 3:10 p.m., two full laundry carts were parked in the Service Corridor Hallway outside the Laundry Room. Additionally, several small boxes were stored in the aforementioned corridor. This finding was acknowledged by the Executive Director at the time of observation and again at the exit conference with the Executive Director and Maintenance Director on 08/10/21 at 3:45 p.m.</p>		<p>re-educated on keeping hallways clear</p> <p>4) How the corrective actions will be monitored:</p> <p>A process has been put in place to ensure that hallways are monitored by the Maintenance Director/designee and that they remain clear. The Maintenance Director/designee will report to the Quality Assurance Committee X2 quarters and rounds to ensure hallways remain clear will be ongoing. The Executive Director will monitor for compliance</p> <p>5) Date of compliance: 09/03/2021</p>	

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K 0351 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING</p> <p>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.</p> <p>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.</p> <p>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 Systems.</p> <p>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)</p> <p>(1) Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in the Linen and Storage Closet in accordance with 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 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</p>	K 0351	<p>Tag: K 351 Scope: E</p> <p>1) Immediate actions taken for those residents identified:</p> <p>No residents were affected by the deficient practice</p>	09/03/2021
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	<p>plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect up to 4 staff.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Executive Director on 08/10/21 between 1:00 p.m. and 3:10 p.m., on the 200 Hall, both the Linen Closet and the Storage Closet had storage stacked within 18 inches of the ceiling. Based on interview at the time of observation, the Executive Director acknowledged the aforementioned sprinkler heads were obstructed.</p> <p>This finding was acknowledged by the Executive Director at the time of observation and again at the exit conference with the Executive Director and Maintenance Director on 08/10/21 at 3:45 p.m.</p> <p>3.1-19(b)</p> <p>(2) Based on observation and interview, the facility failed to maintain the ceiling construction 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 staff and up to 2 staff.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Executive Director on 08/10/21 between 1:00 p.m. and 3:10 p.m., 1 of 1</p>		<p>2) How the facility identified other residents:</p> <p>No other residents have the potential to be affected</p> <p>3) Measures put into place/system changes:</p> <p>All items (linens) were removed to ensure adequate (18 in) clearance from ceiling/sprinkler. The escutcheon missing from the sprinkler head in the maintenance office has been replaced. All staff will be re-educated on adequate storing of items with 18 in clearance from ceiling/sprinkler</p> <p>4) How the corrective action will be monitored:</p> <p>A process has been put in place for the Maintenance Director/designee to check during building rounds to ensure that items stored have appropriate 18 in clearance. The Maintenance Director/designee will report to the Quality Assurance Committee X2 quarters. The Executive Director will monitor for compliance</p> <p>5) Date of compliance: 09/03/2021</p>	

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K 0353 SS=E Bldg. 01	<p>Sprinkler Head in the Maintenance Storage room was missing an escutcheon and did not completely cover the hole around the sprinkler. Based on interview at the time of observation, the Executive Director agreed the aforementioned areas were missing or had improper installed escutcheons. This finding was acknowledged by the Executive Director at the time of observation and again at the exit conference with the Executive Director and Maintenance Director on 08/10/21 at 3:45 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 2 of over 50 sprinkler heads were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011</p>	K 0353	Tag: K 353 Scope: E	09/03/2021

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	<p>edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect 3 staff and up to 4 residents and visitors.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Executive Director on 08/10/21 between 1:00 p.m. and 3:10 p.m., the following sprinkler heads were covered in dust and showed signs of loading:</p> <p>(A) 1 of 3 Sprinkler Heads in resident room 206. (B) 1 of 1 Sprinkler Heads in the Laundry Dryer Room.</p> <p>This finding was acknowledged by the Executive Director at the time of observation and again at the exit conference with the Executive Director and Maintenance Director on 08/10/21 at 3:45 p.m.</p> <p>3.1-19(b)</p>		<p>1) Immediate actions taken for those residents identified:</p> <p>No residents were affected by the deficient practice</p> <p>2) How the facility identified other residents:</p> <p>2 residents housed in room 206 could be affected</p> <p>3) Measures put into place/system changes:</p> <p>The 2 identified sprinkler heads (room 206 & dryer access room) have been cleaned</p> <p>4) How the corrective action will be monitored:</p> <p>A process has been put in place for the Maintenance Director/designee to be checking to ensure sprinkler heads remain free of foreign materials. The Maintenance Director/designee will report to the Quality Assurance Committee X2 quarters and monitoring will be ongoing. The Executive Director will monitor for compliance</p> <p>5) Date of compliance:</p>	

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K 0361 SS=E Bldg. 01	<p>NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 offices with a pass-through window greater than 20 square inches met the requirements of spaces open to the corridor. LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not obstruct access to required exits. LCS 19.3.6.5.1 states miscellaneous openings, such as mail slots, pharmacy pass-through windows, laboratory pass-through windows, and cashier pass-through windows, shall be permitted to be installed in vision panels or doors without special protection, provided that both of the following criteria are met: (1) The aggregate area of openings per room does not exceed 20 inches squared (0.015 m2). (2) The openings are installed at or below half the distance from the floor to the room ceiling. This deficient practice could affect staff and up</p>	K 0361	<p>09/03/2021</p> <p>Tag: K 361 Scope: E</p> <p>1) Immediate actions taken for those residents identified: No residents were affected by the deficient practice</p> <p>2) How the facility identified other residents: All residents have the potential to be affected</p> <p>3) Measures put into place/system changes: An electrically supervised automatic smoke detector was installed in the Business office on 8/26/21</p>	09/03/2021

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K 0363 SS=E Bldg. 01	<p>to 25 staff and residents.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Executive Director on 08/10/21 between 1:00 p.m. and 3:10 p.m., the Office Managers office had a pass-through window and the office was not protected by electrically supervised automatic smoke detection. Based on interview at the time of observation, the Executive Director agreed the window was greater than 20 square inches and the office was not provided with electrically supervised automatic smoke detection.</p> <p>This finding was acknowledged by the Executive Director at the time of observation and again at the exit conference with the Executive Director and Maintenance Director on 08/10/21 at 3:45 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 Corridor - Doors Corridor - Doors</p> <p>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</p>		<p>4) How the corrective actions will be monitored:</p> <p>Maintenance Director/designee will add the Business office to his current system of monitoring smoke detectors throughout the building. Maintenance Director/designee will report smoke detector checks to Quality Assurance Committee X2 quarters and check will continue ongoing. The Executive Director will monitor for compliance.</p> <p>5) Date of compliance: 09/03/2021</p>	

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	<p>flammable or combustible material.</p> <p>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.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect at least 2 residents and 2 staff.</p> <p>Findings include:</p> <p>1. Based on observations during a tour of the facility with the Executive Director on 08/10/21 between 1:00 p.m. and 3:10 p.m., the corridor door to Resident Room 107 failed to close and latch positively into the door frame. Based on</p>	K 0363	<p>Tag: K 363</p> <p>Scope: E</p> <p>1) Immediate actions taken for those residents identified:</p> <p>No residents were affected by this deficient practice</p>	09/03/2021

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K 0372 SS=E Bldg. 01	<p>interview at the time of the observations, the Executive Director agreed the aforementioned corridor door did not close and latch into the door frame and would not resist the passage of smoke. This finding was acknowledged by the Executive Director at the time of observation and again at the exit conference with the Executive Director and Maintenance Director on 08/10/21 at 3:45 p.m.</p> <p>2. Based on observations during a tour of the facility with the Executive Director on 08/10/21 between 1:00 p.m. and 3:10 p.m., room 120, now being used as a storage room, equipped with a self-closing device, failed to close and latch positively into the door frame. Based on interview at the time of the observations, the Executive Director agreed the aforementioned corridor door did not close and latch into the door frame and would not resist the passage of smoke. This finding was acknowledged by the Executive Director at the time of observation and again at the exit conference with the Executive Director and Maintenance Director on 08/10/21 at 3:45 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING</p>		<p>2) How the facility identified other residents: 2 residents (room 107) have the potential to be affected</p> <p>3) Measures put into place/system changes: Maintenance Director made adjustments to the entrance/exit door in room 107 on 8/23/21</p> <p>4) How the corrective actions will be monitored: A process has been put in place for the Maintenance Director to check doors for appropriate latching on his regular building rounds. The Maintenance Director/designee will report to the Quality Assurance Committee X2 quarters and will continue with checks ongoing. The Executive Director will monitor for compliance</p> <p>5) Date of compliance: 09/03/2021</p>	

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	<p>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)</p> <p>Describe any mechanical smoke control system in REMARKS.</p> <p>Based on observation and interview, the facility failed to ensure unsealed holes in 1 of 1 ceiling smoke barriers were protected to maintain the smoke resistance of the ceiling 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 staff I the kitchen and at least 20 residents in the therapy room.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Executive Director on 08/10/21</p>	K 0372	<p>Tag: K 372 Scope: E</p> <p>1) Immediate actions taken for those residents identified:</p> <p>No residents were affected by the deficient practice</p> <p>2) How the facility identified other residents:</p> <p>Up to 20 residents have the potential to be affected</p> <p>3) Measures put in place/system changes:</p> <p>The ceiling penetrations in the therapy room will be patched and repaired by 9/3/21</p> <p>4) How the corrective actions will be monitored:</p>	09/03/2021

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K 0511 SS=E Bldg. 01	<p>between 1:00 p.m. and 3:10 p.m., the therapy room ceiling near the large window contained five 2 inch or greater holes in the ceiling smoke barrier. Based on interview at the time of observation, the Executive Director agreed there were 5 unsealed holes in the ceiling smoke barrier.</p> <p>This finding was acknowledged by the Executive Director at the time of observation and again at the exit conference with the Executive Director and Maintenance Director on 08/10/21 at 3:45 p.m.</p> <p>3.1-19(b)</p> <p>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 over 10 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel,</p>	K 0511	<p>A process has been put in place for the Maintenance Director/designee to check all areas for any type of ceiling/wall penetration that would potentially compromise smoke barriers in the building. The Maintenance Director/designee will report to the Quality Assurance Committee X2 quarters and checks will continue ongoing. The Executive Director will monitor for compliance</p> <p>5) Date of compliance: 09/03/2021</p> <p>Tag: K 511 Scope: E</p> <p>1) Immediate actions taken for those residents identified:</p>	09/03/2021

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	<p>states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location.</p> <p>(B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B) (1) through (8) shall have ground-fault circuit-interrupter protection for personnel.</p> <p>(1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors</p> <p>Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable.</p> <p>Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection.</p> <p>(5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink.</p> <p>Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection.</p> <p>Exception No. 2 to (5): For receptacles located in patient bed locations of general care or</p>		<p>No residents were affected by the deficient practice</p> <p>2) How the facility identified other residents: Up to 16 residents have the potential to be affected</p> <p>3) Measures put into place/system changes: A new GFI outlet has been installed in the ice machine room. The ice machine will be relocated to a more suitable location by 9/3/21</p> <p>4) How the corrective actions will be monitored: A process has been put in place to check for appropriate wiring and will be checked regularly by the Maintenance Director/designee. The Maintenance Director/designee will report to the Quality Assurance Committee X2 quarters. The Executive Director will monitor for compliance</p> <p>5) Date of compliance: 09/03/2021</p>	

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	<p>critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required.</p> <p>(6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff while at the ice machines.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Executive Director on 08/10/21 between 1:00 p.m. and 3:10 p.m., the ice machine in the Ice Machine Room was connected to an extension cord which was wired to a ceiling light and being used to power the freestanding ice machine, with its own water supply. The ice machine, located within 3 feet of electric connection which did not provided the appliance with ground fault circuit interrupters (GFCI).</p> <p>This finding was acknowledged by the Executive Director at the time of observation and again at the exit conference with the Executive Director and Maintenance Director on 08/10/21 at 3:45 p.m.</p> <p>(2) Based on observation and interview, the facility failed to ensure in 1 of 1 Ice Machine</p>			

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K 0524 SS=E Bldg. 01	<p>Room flexible cords were not used 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. This deficient practice affects staff and up to 16 residents in the main corridor.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Executive Director on 08/10/21 between 1:00 p.m. and 3:10 p.m., the Ice Machine in the Ice Machine room was being powered by a flexible extension cord, partially concealed in snap together plastic conduit wired into the overhead ceiling light.</p> <p>This finding was acknowledged by the Executive Director at the time of observation and again at the exit conference with the Executive Director and Maintenance Director on 08/10/21 at 3:45 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 HVAC - Direct-Vent Gas Fireplaces Direct-Vent Gas Fireplaces Direct-vent gas fireplaces, as defined in NFPA 54, inside of all smoke compartments containing patient sleeping areas comply with the requirements of 18.5.2.3(2), 19.5.2.3(2), 18.5.2.3(2), 19.5.2.3(2), NFPA 54</p> <p>Based on observation and interview; the facility failed to ensure 1 of 1 direct-vent fireplace located in a smoke compartment containing resident sleeping rooms was protected with a</p>	K 0524	Tag: K 524 Scope: E	09/03/2021

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	<p>carbon monoxide detection. LSC 19.5.2.3 (2) (f) states electrically supervised carbon monoxide detection in accordance with Section 9.8 shall be provided in the room where the fireplace is located. This deficient practice could affect up to 25 residents that would use the common lounge area.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Executive Director on 08/10/21 between 1:00 p.m. and 3:10 p.m., in the lounge area there was a direct-vent fireplace. The lounge was located within a smoke compartment containing resident sleeping rooms. The lounge area room did have smoke detectors, but it was unknown if the detectors detected carbon monoxide. Based on interview at the time of observation, the Executive Director stated they did not know if the lounge area was equipped with carbon monoxide detection.</p> <p>This finding was acknowledged by the Executive Director at the time of observation and again at the exit conference with the Executive Director and Maintenance Director on 08/10/21 at 3:45 p.m.</p> <p>3.1-19(b)</p>		<p>1) Immediate actions taken for those residents identified: No residents were affected by the deficient practice</p> <p>2) How the facility identified other residents: Up to 25 residents have the potential to be affected</p> <p>3) Measures put into place/system changes: A carbon monoxide detector was ordered 8/25/21 and will be installed upon receipt</p> <p>4) How the corrective actions will be monitored: The Maintenance Director/designee will check the carbon monoxide detector during regular building rounds. The Maintenance Director/designee will report to the Quality Assurance Committee X2 quarters. The Executive Director will monitor for compliance</p> <p>5) Date of compliance: 09/03/2021</p>	

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K 0712 SS=C Bldg. 01	<p>NFPA 101 Fire Drills Fire Drills</p> <p>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 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.</p> <p>19.7.1.4 through 19.7.1.7</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills on unexpected days under varying conditions. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on records review of the "Monthly Fire Drill Record" and interview with the Executive Director on 08/10/21 between 10:10 a.m. and 12:45 p.m., 10 of 12 fire drills were conducted near the end of the month, on or near the 27th day - 30th day of the month. These conditions do not allow fire drills to be conducted at unexpected times. This finding was acknowledged by the Executive Director at the time of observation and again at the exit conference with the Executive Director and Maintenance Director on 08/10/21 at 3:45 p.m.</p> <p>3.1-19(b)</p>	K 0712	<p>Tag: K 712 Scope: C</p> <p>1) Immediate actions taken for those residents identified: No residents were affected by the deficient practice</p> <p>2) How the facility identified other residents: All residents have the potential to be affected</p> <p>3) Measures put into place/system changes:</p>	09/03/2021
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K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits		Fire drills will be scheduled by the Maintenance Director and conducting avoiding any pattern of occurrence 4) How the corrective actions will be monitored: Maintenance Director/designee will review and report drills to the Quality Assurance Committee X2 quarters. The Executive Director will monitor for compliance 5) Date of compliance: 09/03/2021	

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	<p>smoking shall not be required.</p> <p>(3) Smoking by patients classified as not responsible shall be prohibited.</p> <p>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.</p> <p>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</p> <p>(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.</p> <p>18.7.4, 19.7.4</p> <p>Based on observation and interview; the facility failed to ensure 1 of 3 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect staff and 5 or more residents in the smoking area.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Executive Director on 08/10/21 between 1:00 p.m. and 3:10 p.m., in the resident smoking area there were over 30 cigarette butts disposed on the ground in and around the smoking area. Based on interview at the time of observations, the Executive Director concluded there were over 30 cigarette butts on the ground in the aforementioned location.</p> <p>This finding was acknowledged by the Executive Director at the time of observation and again at the exit conference with the Executive Director and Maintenance Director on 08/10/21 at 3:45 p.m.</p> <p>3.1-19(b)</p>	K 0741	<p>Tag: K 741 Scope: E</p> <p>1) Immediate actions taken for those residents identified: No residents were affected by the deficient practice</p> <p>2) How the facility identified other residents: Up to 5 residents have the potential to be affected</p> <p>3) Measures put into place/system changes: Staff will be re-educated regarding the facility smoking</p>	09/03/2021

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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) assemblies 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		policy and appropriate disposal of cigarette butts 4) How the corrective actions will be monitored: A process has been put in place to add checking for appropriate disposal of cigarette butts to the building rounds for the Maintenance Director/designee. The Maintenance Director/designee will report to the Quality Assurance Committee X2 quarters and rounds will continue ongoing. The Executive Director will monitor for compliance 5) Date of compliance: 09/03/2021	

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	<p>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</p> <p>Based on observation and interview, the facility failed to ensure power strips in the nurses station were of UL rating of 1363A or 60601-1. 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 affects 5 staff.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Executive Director on 08/10/21 between 1:00 p.m. and 3:10 p.m., the power strip being used in the Main Nurses Station lacked a UL rating of 1363A or 60601-1 label. This finding was acknowledged by the Executive Director at the time of observation and again at the exit conference with the Executive Director and Maintenance Director on 08/10/21 at 3:45 p.m.</p> <p>3.1-19(b)</p>	K 0920	<p>Tag: K 920 Scope: E</p> <p>1) Immediate actions taken for those residents identified: No residents were affected by the deficient practice</p> <p>2) How the facility identified other residents: No residents have the potential to be affected</p> <p>3) Measures put into place/system changes: An acceptable power strip was ordered 8/25/21 and will be installed upon receipt</p>	09/03/2021

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K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.		4) How the corrective actions will be monitored: A process has been put in place and added to regular rounds for the Maintenance Director/designee to check that an appropriate power strip is in place throughout the building. The Maintenance Director/designee will report to the Quality Assurance Committee X2 quarters. 5) Date of compliance: 09/03/2021	

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	<p>Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.</p> <p>A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 storage locations of nonflammable gases equal to or greater than 3000 cubic feet were secured against unauthorized entry. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2.1 states storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. This deficient practice could affect 25 staff and visitors in the vicinity of the oxygen storage.</p> <p>Findings include:</p>	K 0923	<p>Tag: K 923 Scope: E</p> <p>1) Immediate actions taken for those residents identified: No residents were affected by the deficient practice</p> <p>2) How the facility identified other residents: No residents have the potential to</p>	09/03/2021
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	<p>Based on observations during a tour of the facility with the Executive Director on 08/10/21 between 1:00 p.m. and 3:10 p.m., the fenced oxygen storage location exterior of the building was not locked or did it provide other means to secure against unauthorized entry. Based on interview at the time of the observations, the Executive Director stated the oxygen was no longer going to be stored in this location once the new management takes over the facility. This finding was acknowledged by the Executive Director at the time of observation and again at the exit conference with the Executive Director and Maintenance Director on 08/10/21 at 3:45 p.m.</p> <p>3.1-19(b)</p>		<p>be affected</p> <p>3) Measures put into place/system changes:</p> <p>The oxygen storage area has been secured awaiting final disposition of remaining oxygen tanks</p> <p>4) How the corrective actions will be monitored:</p> <p>The Maintenance Director/designee will check on regular facility rounds to ensure the current oxygen storage area remains locked until the final tanks are removed. The Maintenance Director/designee will report to the Quality Assurance Committee until tanks are disposed of. The Executive Director will monitor for compliance</p> <p>5) Date of compliance: 09/03/2021</p>		