STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155654	A. BUILDING -- B. WING	08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENGLEWOOD HEALTH & REHABILITATION CENTER	2237 ENGLE RD FORT WAYNE, IN 46809

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/03/23 Facility Number: 000498 Provider Number: 155654 AIM Number: 100266110 At this Emergency Preparedness survey, Englewood Health & Rehabilitation Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 67 certified beds. At the time of the survey, the census was 50. Quality Review completed on 08/08/23	E 0000	The following plan of correction constitutes our written allegation of compliance for the deficiencies cited. Submission of this plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correction is submitted to meet the requirements established by State and Federal law. This facility respectfully requests paper compliance for the deficiencies cited.	
E 0037 SS=C Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rose Smalley	Regulatory Compliance Director	08/24/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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

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

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	and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility	E 0037	**E037 EP Training Program**	08/16/2023

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	failed to ensure staff could demonstrate knowledge of emergency procedures Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d)(1). This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Maintenance Director on 08/03/23 at 10:11 a.m., the annual EEP training conducted between January 2023 and June 2023 did not have documentation to show staff could demonstrate knowledge of the EPP. Based on an interview at the time of records review, the Maintenance Director stated no type of testing was provided after the EPP training. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		**Plan of Correction** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** At the time the deficiency was identified, no residents were found to have been affected by the deficient practice. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents had the potential to be affected by the deficient practice and all staff in the facility had the potential to be affected, but no employee or resident was affected. **3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur?** Maintenance director immediately conducted tests for employees to ensure that staff could demonstrate knowledge of the EPP. Maintenance Director/designee will implement	

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			the “Emergency Preparedness Regulation” course through our Relias training/testing program for employees to demonstrate knowledge of EPP annually. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? ie: what QA program will be put into place and by what date will they be completed.** Relias “Emergency Preparedness Regulation” course must be passed by each employee annually. New hires will be required to complete course during orientation process.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct			

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	exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must			

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	conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual			

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	facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences			

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	an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required			

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	full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or			

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	individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may			

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	155654	A. BUILDING -- B. WING	08/03/2023

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	include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.			

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	*[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a	E 0039	**E039 EP Testing Requirements** **Plan of Correction** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** At the time the deficiency was identified, no residents were found to have been affected by the deficient practice. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents had the potential to be affected by the deficient practice and all staff in the facility	08/18/2023

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	facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 08/03/23 at 10:12 a.m., there was documentation for an actual drill on 04/25/23, but no documentation of an additional exercise of choice was available for review. Based on interview at the time of records review, the Maintenance Director stated additional exercise of choice was not conducted with in the last year. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		had the potential to be affected, but no employee or resident was affected. **3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur?** Tabletop exercise is scheduled for all department heads on 8/17/2023 which will be led by Maintenance Director that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, and prepared questions designed to challenge our Active Shooter emergency plan. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** **ie: what QA program will be put into place and by what date will they be completed.** Maintenance director/designee will ensure the facility maintains training compliance with two scheduled Emergency Preparedness testing requirements annually.	

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/03/23 Facility Number: 000498 Provider Number: 155654 AIM Number: 100266110 At this Life Safety Code survey, Englewood Health & Rehabilitation Center was found not in compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety From Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and has hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 67 and had a census of 50 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for three detached storage buildings. Quality Review completed on 08/08/23	K 0000	The following plan of correction constitutes our written allegation of compliance for the deficiencies cited. Submission of this plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correction is submitted to meet the requirements established by State and Federal law. This facility respectfully requests paper compliance for the deficiencies cited.	

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K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485			

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	Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of 9 resident room doors on the 200-hall resist the passage of smoke and capable of resisting fire for at least 20 minutes. This deficient practice could affect 2 residents in room 212. Findings include: Based on observation with the Maintenance Director on 08/03/23 at 10:20 a.m. resident room corridor door 212 had up to a ½ inch gap between the top of the door and the door frame. Based on interview at the time of observation, the Maintenance Director agreed there was a ½ inch gap between the top of the door and the door frame. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0363	**K363 Corridor - Doors** **Plan of Correction** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** At the time the deficiency was identified, no residents were found to have been affected by the deficient practice. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** Two residents had the potential to have been affected by the deficient practice. **3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur?** The door frame and top hinge were adjusted to lessen the ½ inch gap between the top of the door and the door frame. The Maintenance Director also put foam on the door	08/16/2023

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			to ensure there is no gap between the door and door frame. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** **ie: what QA program will be put into place and by what date will they be completed.** Maintenance director audited all doors to ensure there is no gap between the door and door frame. All doors are in compliance with regulation.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation, the facility failed to ensure 1 of 1 electrical splices were made in a junction box. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. Article 322.56 (A) states splices shall be made in listed junction boxes. This deficient practice could affect 8 residents in the front part of the 300-hall. Findings include: Based on observation with the Maintenance	K 0511	**K511 – Utilities – Gas and Electric** **<u>Plan of Correction</u>** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** At the time the deficiency was	08/16/2023

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	Director on 08/03/23 at 11:45 a.m. in the breakroom above the ceiling tiles by the attic hatch there were electrical spliced wires hanging out of the ceiling that were not contained inside a junction box. Based on interview at the time of the observations, the Maintenance Director acknowledged there were electrical splices that were not protected with a junction box. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		identified, no residents were found to have been affected by the deficient practice. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** Eight residents had the potential to be affected by the deficient practice. **3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur?** Maintenance Director installed a junction box cover and fire caulked around the cover to ensure there were no gaps. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** **ie: what QA program will be put into place and by what date will they be completed.** All electrical spliced wires are now safely contained inside of a junction box.	

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K 0911 SS=E Bldg. 01	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) Based on observation and interview, the facility failed to ensure access and working space was maintained for 2 of 2 electrical panels in the Fire Control Panel (FCP) mechanical room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A) (1), (2) and (3). 110.26(A) (1) states the depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) which the minimum clear distance is 3 feet. 110.26(A) (2) states the width of the working space in front of the electrical equipment shall be the width of the equipment or 762 mm (30 in.), whichever is greater. In all cases, the workspace shall permit at least a 90-degree opening of equipment doors or hinged panels. 110.26(A)(3) states the workspace shall be clear and extend from the grade, floor, or platform to a height of 61?2 feet or the height of the equipment, whichever is greater. Article 110.26(B)	K 0911	**K911 Electrical Systems - Other** **Plan of Correction** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** At the time the deficiency was identified, no residents were found to have been affected by the deficient practice. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** The deficient practice had the potential to affect the 30 residents in the 100 and 200 halls. **3. What measures will be put into place or what systemic changes will be made to**	08/18/2023

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	states the working space required by this section shall not be used for storage. This deficient practice could affect 30 residents in the 100 and 200 halls. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 08/04/23 at 10:41 a.m., the two electrical panels in the FCP mechanical room were blocked from access with and tool cart and other items stored in front of the panels. Based on interview at the time of the observations, the Maintenance Director agreed items were stored within the working space in front of the electrical panels. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**ensure that deficient practice does not recur?** Items were removed from the mechanical room to allow a clear pathway to access the electrical panels. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** **ie: what QA program will be put into place and by what date will they be completed.** The supplies will no longer be stored in mechanical room to ensure there is a clear pathway to electrical panels.	
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			

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	sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. 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. 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." 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. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure a minimum distance of at least five feet separated combustible materials from oxygen storage equipment in 1 of 1 oxygen trans-filling rooms. NFPA 99, 11.3.2.3 requires oxidizing gases such as oxygen shall be separated from combustibles by one of the following: (1) a minimum distance of 20 feet. (2) a minimum distance of 5 feet if the required storage location is protected by an automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. (3) Enclosed cabinet of noncombustible construction having a	K 0923	**K923 – Gas Equipment – Cylinder and Container Storage** **<u>Plan of Correction</u>** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** At the time the deficiency was	08/18/2023

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	minimum fire protection rating of ½ hour. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation during the tour of the facility with the Maintenance Director on 08/03/22 at 10:30 a.m., three wooden shelves were within five feet of stationary liquid oxygen containers in the oxygen storage and trans-filling room. Based on interview at the time of observation, the Maintenance Director agreed combustible shelving was within five feet of stationary liquid oxygen containers. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		identified, no residents were found to have been affected by the deficient practice. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** The deficient practice had the potential to affect 20 residents in one smoke compartment. **3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur?** The three wooden shelves were removed, and metal shelves were installed as non-combustible shelves. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** **ie: what QA program will be put into place and by what date will they be completed.** Noncombustible items will no longer be stored in oxygen storage room.	