STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155717	A. BUILDING -- B. WING	12/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALPHA HOME - A WATERS COMMUNITY	2640 COLD SPRING RD INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/16/19 Facility Number: 000376 Provider Number: 155717 AIM Number: 100275510 At this Emergency Preparedness survey, Alpha Home - a Waters Community was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 86 certified beds. At the time of the survey, the census was 57. Quality Review completed on 12/23/19	E 0000	In lieu of revisit, I would like respectively request a desk review	
E 0039 SS=C 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 *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the			

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

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	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):]			

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	(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the 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			

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	per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (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,			

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	CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that 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 LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per			

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	year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed 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)]:			

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

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	(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.			
	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.	E 0039	1. **CORRECTIVE ACTIONS TAKEN**: a. On **05/2/2019** the Administrator and the Maintenance Supervisor/designee conducted an individual, facility-based functional emergency exercise and document the drill to meet set standards. On 01/08/2020 the Administrator and the Maintenance Supervisor/designee will conduct another individual, facility-based functional emergency exercise and document the drill to meet set standards 2. **ALL OTHERS WITH**	01/15/2020

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	(ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review on 12/16/19 at 10:48 a.m. with the facilities visiting Maintenance Director, the facility conducted an "Elopement drill" - tabletop exercise on 09/06/2019. They also conducted a "Tornado drill - tabletop exercise on 08/14/2019. The facility failed to conduct a full-scale exercise that is community-based or an individual, facility-based functional exercise within the last year. Based on interview at the time of the record review, the visiting Maintenance Director advised he was just at the facility to help out, and had no idea where any other emergency preparedness paperwork or documentation could be found. During the exit conference with the facilities visiting Maintenance Director and the regional Maintenance Director on 12/16/19 at 1:25 p.m., no additional information or evidence could be provided contrary to this deficient finding.		**POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 01/06/2020 the Administrator in-serviced the Maintenance Supervisor/designee on the requirement that a community-based full-scale exercise or an individual, facility-based functional exercise must be conducted at least annually and documented to meet set standards. b. Maintenance Supervisor/designee will insure all required exercises are conducted at least twice per year to test the emergency plan as a part of the facility's Emergency Preparedness Program and document exercise results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. c. The Administrator will monitor adherence to Emergency Preparedness Plan and validate the Emergency Preparedness Plan documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The results will be presented by the Administrator and the Maintenance Supervisor/designee and the Administrator will present the results at a Quality	

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			Assurance/Performance Improvement (QA/PI) meeting. The results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 01/15/2020.**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/16/19 Facility Number: 000376 Provider Number: 155717 AIM Number: 100275510 At this Life Safety Code survey, Alpha Home - a Waters Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of	K 0000	In lieu of revisit, I would like respectively request a desk review	

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	Type V (111) construction and fully sprinkled. The facility has a fire alarm system with hard wired smoke detection in the corridors, spaces open to the corridors, and in all resident sleeping rooms. The facility has a capacity of 86 and had a census of 57 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except for one detached storage shed. Quality Review completed on 12/23/19			
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual	K 0345	1. **CORRECTIVE ACTIONS TAKEN**: a. On 06/04/2019 a certified fire alarm contractor conducted a visual semi-annual fire alarm system inspection and provided the facility with documentation of the inspection results to meet set standards. The Administrator verified the inspection and documentation on 12/27/2019. 2. **ALL OTHERS WITH**	01/15/2020

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	fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: During record review with the visiting Maintenance Director on 12/16/19 at 10:36 a.m., no documentation could be provided regarding a visual semi-annual fire alarm system inspection. Based on interview at the time of record review, the visiting Maintenance Director agreed that the documentation of a visual semi-annually inspection of the fire-alarm system was not available for review at the time of this survey. 3.1-19(b)		**POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. The facility has only one fire alarm system. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 01/06/2020 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that semi-annual visual inspections must be performed on the facility's fire alarm system and documentation retained to meet set standards. b. Maintenance Supervisor/designee will insure a certified fire alarm contractor conducts the semi-annual visual inspections on the fire alarm system and will retain documentation of those inspections as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.	

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			4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 01/15/2020.**	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 2 of 17 portable fire extinguishers were installed in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than five feet above the floor. This	K 0355	1. **CORRECTIVE ACTIONS TAKEN**: a. On 01/03/2020 the Maintenance Supervisor/designee reaired the portable fire extinguisher in the 100 Hall Mechanical Room and the portable fire extinguisher in the	01/15/2020

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	deficient practice could affect as many as 4 residents and 6 staff. Findings include: Based on observation with the visiting Maintenance Director during a tour of the facility from 11:30 a.m. to 1:40 p.m. on 12/16/19, the following as noted: a) The portable fire extinguisher located in the 100 hall Mechanical room was mounted on the wall with the top of the extinguisher 5 feet 7 inches above the floor. b) The portable fire extinguisher located in the Employee break room was mounted on the wall with the top of the extinguisher 5 feet 4 inches above the floor. Based on interview at the time of each observation, the visiting Maintenance Director stated that he would remind the Maintenance Man that portable fire extinguishers could not be mounted with the tops of the handle more than 60 inches (5 feet) above the floor. 3.1-19(b)		Employee Break Room so the tops of the extinguishers are not more than 5 feet above the floor to meet set standards. The Administrator verified the repositioning on 01/03/2020. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 01/03/2020 the Maintenance Supervisor/designee inspected all portable fire extinguishers throughout the facility and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 01/06/2020 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that portable fire extinguishers with a gross weight not over 40 pounds must be mounted so the tops of the extinguishers are not more than 5 feet above the floor to meet set standards. b. Maintenance Supervisor/designee will inspect all fire extinguishers throughout the facility monthly to insure the tops of the fire extinguishers are at no more than 5 feet above the floor as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed	

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			and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 1/15/2020.**	
K 0363 SS=E 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			

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	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 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 3 of 40 sets of resident room doors to the corridor would close completely and	K 0363	1. **CORRECTIVE ACTIONS TAKEN**: a. On 01/06/2020 the	01/15/2020

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	latch into the door frame. This deficient practice could affect approximately 24 residents, as well as staff and visitors. Findings include: Based on observation with the visiting Maintenance Director during a tour of the facility from 11:30 a.m. to 1:40 p.m. on 12/16/19, the following as noted: 1) Resident room #108 failed to close and latch into the frame 2) Resident room #303 failed to close and latch into the frame 3) Resident room #304 failed to close and latch into the frame Based on interview at the time of observations, visiting Maintenance Director acknowledged the aforementioned resident room doors not fully closing or latching into the doorframes. 3.1-19(b)		Maintenance Supervisor/designee repaired the corridor doors to resident Room #108, Room #303, and Room #304 so they closed fully and latched completely into the frame to meet set standards. The Administrator verified the repairs on 01/06/2020. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 01/06/2020 the Maintenance Supervisor/designee tested all resident room corridor doors to insure they closed fully and latched completely into the frames and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 01/06/2020 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that all resident room corridor doors must close fully and latch completely into the frames to meet set standards. b. Maintenance Supervisor/designee will test all resident room corridor doors throughout the facility monthly to insure they close fully and latch completely into the frames as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are	

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			discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 1/15/20.**	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors			

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	2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 4 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect as many as 18 residents, as well as staff and visitors on the 100 hall. Findings include: Based on observation with the visiting Maintenance Director during a tour of the facility at 11:31 a.m. on 12/16/19, the set of smoke barrier doors located in the 100 hall near resident room #102 did not fully close or latch into the door frame. There was a one inch gap between the doors when closed to their fullest. Based on interview during the time of observation, the visiting Maintenance Director acknowledged these smoke barrier doors did not close and / or latch into the door frame. 3.1-19(b)	K 0374	1. **CORRECTIVE ACTIONS TAKEN**: a. On 01/06/20 the Maintenance Supervisor/designee repaired the set of smoke barrier doors in the 100 Hall near resident Room #102 to remove the 1" gap between the doors and to fully close and latch into the door frame to meet set standards. The Administrator verified the repairs on 01/06/20. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 01/06/20 the Maintenance Supervisor/designee tested all smoke barrier doors to insure they properly closed and latched and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 01/06/20 the Administrator inserviced the Maintenance Supervisor/designee	01/15/2020

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			on the requirement that smoke barrier doors must be free of gaps and must close fully and latch into the door frames to meet set standards. b. Maintenance Supervisor/designee will test all smoke barrier doors throughout the facility monthly to insure they properly close and latch into the door frames as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction	

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			developed and implemented as deemed necessary to insure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 01/15/20.**	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills for 2 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: During record review with the visiting Maintenance Director on 12/16/19 at 9:50 a.m., no documentation could be provided regarding a fire drill for the first quarter (January, February, or March) of 2019 or a fourth quarter (October, November, or December) third shift fire drill for	K 0712	1. **CORRECTIVE ACTIONS TAKEN**: a. On 01/6/20 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that quarterly fire drills must be conducted on each shift under varied conditions and documented to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were.	01/15/2020

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	2018. Based on interview at the time of record review, the visiting Maintenance Director acknowledged that there was no additional available fire drill documentation available for review at the time of this survey. 3.1-19(b) 3.1-51(c)		3. **MEASURES TO PREVENT REOCCURRENCE**: a. Maintenance Supervisor/designee will conduct at least 1 fire drill per quarter per shift at varied times and retain documentation of those drills as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. b. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained. **This plan of correction**	

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			constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 01/15/2020.	
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 in enclosures housing electrical apparatus in 1 of 1 electrical room on the 100 hall. 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 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). Distances shall be measured from the live parts if such parts are exposed or from the enclosure front or opening if such are enclosed. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect 24 residents, as well as 4 staff and 2 visitors on the 100 hall. Findings include:	K 0911	1. **CORRECTIVE ACTIONS TAKEN**: a. On 01/06/2020 the Maintenance Supervisor/designee removed the chair, folding table, and cardboard box with cleaning supplies from in front of and under the electrical panel in the 100 Hall within the Electrical Room next to resident Room #106 to meet set standards. The Administrator verified the removal and documentation on 01/06/2020 . 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 01/06/2020 the Maintenance Supervisor/designee inspected all electrical panels throughout the facility to insure access and	01/15/2020

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	Based on observation with the visiting Maintenance Director during a tour of the facility at 11:31 a.m. on 12/16/19, the electrical panel located on the 100 hall within the electrical room next to resident room #106 had a chair, folding table, and a cardboard box with cleaning supplies stored directly in front of and under the electrical panel. Based on interview at the time of the observations, the visiting Maintenance Director acknowledged the aforementioned items were stored within three feet of the working space in front of electrical panel in the electrical room on the 100 hall. 3.1-19(b)		working space was maintained and found no other negative findings 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 01/06/2020 the Administrator inserviced the Maintenance Supervisor/designee and all other staff on the requirement that access and working space must be maintained and remain clear near all facility electrical panels to meet set standards. b. Maintenance Supervisor/designee will inspect all electrical panel areas throughout the facility weekly to insure they remain clear and are easily accessible as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the	

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			Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 01/15/2020.**	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are			

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	tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and interview, the facility failed to ensure 276 of 276 nonhospital-grade electrical receptacles at resident room locations were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on observations with the visiting Maintenance Director during a tour of the facility from 1130 a.m. to 1:40 p.m. on 12/16/19, the facility's 46 resident rooms had roughly 6 electrical receptacles in each room. Based on interview at the time of the observation, the visiting Maintenance Director indicated all of the electrical receptacles in the resident rooms were not hospital-grade and also indicated there was no	K 0914	1. **CORRECTIVE ACTIONS TAKEN**: a. On **01/6/2020** the Maintenance Supervisor/designee inspected all non-hospital grade electrical receptacles and documented the inspection results on the Receptacle Testing Log to meet set standards. The Administrator verified the inspection and documentation on 01/06/2020 . 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 01/06/2020 the Administrator in-serviced the Maintenance Supervisor/designee on the policy that all non-hospital grade electrical receptacles must be tested annually and those test results documented on the Receptacle Testing Log to meet set standards. b. Maintenance Supervisor/designee will insure all non-hospital grade electrical receptacles throughout the facility are be tested annually and those	01/15/2020

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	documentation available for review of annual testing per NFPA 99, Receptacle Testing requirements. 3.1-19(b)		test results documented on the Receptacle Testing Log as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 01/15/2020.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. BUILDING 01 B. WING	12/16/2019

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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. 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			

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	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 storage areas. 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 minimum fire protection rating of ½ hour. This deficient practice could affect any resident, staff or visitor in the vicinity of the oxygen storage and transfilling room. Findings include: Based on observation with the visiting Maintenance Director during a tour of the facility at 11:38 a.m. on 12/16/19, three 86 inch long by 8 inch wide sections of peg board and one 54 inch long by 8 inch wide section of peg board were mounted on the wall within five feet of stationary liquid oxygen containers in the oxygen storage and transfilling room. Based on interview at the time of observation, the visiting Maintenance Director acknowledged the peg board as being a combustible material and that it was stored within five feet of stationary liquid oxygen containers in the oxygen transfilling room. 3.1-19(b)	K 0923	1. **CORRECTIVE ACTIONS TAKEN**: a. On 01/06/2020 the Maintenance Supervisor/designee removed the 4 sections of peg board from the wall within 5 feet of the stationary liquid oxygen containers in the Oxygen Storage and Transfilling Room to meet set standards. The Administrator verified the removal on 01/06/2020. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. The facility has only one Oxygen Storage and Transfilling Room. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 01/06/2020 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that combustible materials must be separated from oxygen storage equipment by a minimum of 5 feet to meet set standards. b. Maintenance Supervisor/designee will inspect the Oxygen Storage and Transfilling Room weekly to insure no combustible materials are stored within 5 feet of the oxygen storage equipment as a part of the	01/15/2020

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			facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 01/15/2020.**	