| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155762 | A. BUILDING -- B. WING | 02/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| FOREST PARK HEALTH CAMPUS | 2401 SOUTH L ST RICHMOND, IN 47374 |

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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 02/17/25<br><br>Facility Number: 011387<br>Provider Number: 155762<br>AIM Number: 200853180<br><br>At this Emergency Preparedness survey, Forest Park Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.<br><br>The facility has 70 certified beds. At the time of the survey the census was 56.<br><br>Quality Review completed on 02/21/25 | E 0000 | | |
| K 0000<br><br>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).<br><br>Survey Date: 02/17/25<br><br>Facility Number: 011387<br>Provider Number: 155762<br>AIM Number: 200853180<br><br>At this Life Safety Code survey, Forest Park Health Campus was found not in compliance with | K 0000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Karen Marzec | Executive Director | 03/06/2025 |

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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| | Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>This facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, all areas open to the corridor and has smoke detectors hard-wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 70 and had a census of 56 at the time of this survey.<br><br>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.<br><br>Quality Review completed on 02/21/25 | | | |
| K 0161<br>SS=F<br>Bldg. 01 | NFPA 101<br>Building Construction Type and Height<br><br>Based on record review, observation and interview; the facility failed to maintain the building construction type for a facility with Type V(111) construction. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of facility blueprint documentation dated 04/14/05 with the Director of Plant Operations (DPO) and the Facilities Management Support during record review from 9:50 a.m. to 12:40 p.m. on 02/17/25, the construction type for the facility was Type V(111). In addition, a one-hour fire barrier wall is | K 0161 | **K—0161**<br>Compliance Date 2/20/2025<br>Immediate intervention<br>The Director of Plant Operations purchased NFPA approved fire caulk and applied to penetration areas in the attics one-hour fire barrier wall separating the Living Room and Health Club portion of the facility.<br>Director of Plant Operations will continue to monitor this area, to assure that if any penetrations occur they will be immediately repaired and that we | 02/20/2025 |

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| | constructed from the floor to the underside of the roof in the wall separating the Living Room and Health Club portion of the facility from the smoke compartment containing the nurse's station.<br>Based on observations with the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 12:40 p.m. to 2:15 p.m. on 02/17/25, a two inch in diameter hole was noted in the one-hour fire barrier wall in the attic above the corridor door set by the nurse's station. The hole was not firestopped and was for the passage of one electrical conduit through the wall near the HVAC equipment installed in the attic. In addition, a separate three inch in diameter hole was also noted in the one-hour fire barrier wall in the attic above the corridor door set by the nurse's station. The hole was not firestopped and was for the passage of multiple data cables through the wall. Based on interview at the time of the observations, the DPO agreed the aforementioned holes in the one-hour fire barrier wall in the attic above the corridor door set by the nurse's station did not maintain the building construction type.<br><br>These findings were reviewed with the Executive Director, the DPO and the Facilities Management Support during the exit conference.<br><br>3.1-19(b) | | do not have any other concerns with issues like this when work is done in the attic.<br>Director of Plant Operations Audit will consist of 1 X per month for 3 Months.<br>Education, Facilities Management of Central Ohio regional Trilogy Health Services has conducted an in-service with the Director of Maintenance on monitoring any area of protection to prevent the passage of smoke where protection is required.<br>This had the potential to affect 56 residents.<br>The Executive director will present results of visual inspection through the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance with has been achieved.<br><br>See Exhibits<br>(Exhibit A) Photo of first hole penetration after repaired.<br>(Exhibit B) Photo of second hole penetration after repair<br>(Exhibit B1) Photo of fire caulking | |
| K 0293<br>SS=E<br>Bldg. 01 | NFPA 101<br>Exit Signage<br><br>Based on observation and interview; the facility failed to provide clear direction with exit signage in 1 of 8 exits in accordance with LSC 7.10. LSC | K 0293 | **K293 – Exit Signage**<br><br>Compliance Date | 02/25/2025 |

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| | 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Salon near the main entrance lobby to the health care portion of the facility.<br><br>Findings include:<br><br>Based on observations with the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 12:40 p.m. to 2:15 p.m. on 02/17/25, the exit door to the courtyard by the Salon was marked as a facility exit with an 'EXIT' sign. However, a sign was also affixed to the wall next to the exit door stating "Courtyard Not an Exit". Based on interview, the DPO stated the courtyard has an exit to the public way and the courtyard could be used as an exit but was not intended to be a facility exit and agreed exit signage by the Salon door created confusion as to whether or not the door to the courtyard was a facility exit or not.<br><br>These findings were reviewed with the Executive Director, the DPO and the Facilities Management Support during the exit conference.<br><br>3.1-19(b) | | _2_/_25_/___2025_<br><br>**Immediate Intervention**<br>The Director of Plant Operations has removed the “Courtyard Not An Exit” signage from the wall by the salon marking the exit to the courtyard. The Director of Plant Operations added proper NFPA required signage on the exit door identifying it as an emergency exit.<br><br>The Director of Plant Operations was educated by the Executive Director on K293 – Exit Signage, NFPA 101, 2012 Existing. Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also serve by the emergency lighting system 19.2.10.1<br><br>The Director of Plant Operations will conduct audit of corridor for proper signage of Exit or No Exit for leading to the exterior of corridor. 1 x per week x 3 months.<br><br>Results of these audits will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.<br><br>This deficient practice could affect staff and at least 10 residents. | |

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| | | | (Exhibit C) photo of Courtyard Not An Exit Sign after removal.<br>(Exhibit D) photo of proper signage on exit door. | |
| K 0341<br>SS=F<br>Bldg. 01 | NFPA 101<br>Fire Alarm System - Installation<br><br>Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 2010 Edition. Section 10.5.5.2.1 states, the location of the dedicated branch circuit disconnecting means shall be permanently identified at the control unit. Section 10.5.5.2.2 states, for fire alarm systems the circuit disconnecting means shall be identified as "FIRE ALARM CIRCUIT." Section 10.5.5.2.3 states for fire alarm systems the circuit disconnecting means shall have a red marking. Section 10.5.5.2.4 states the circuit disconnecting means shall be accessible only to authorized personnel. Section 10.5.5.3 states the dedicated branch circuit(s) and connections shall be protected against physical damage. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on observations with the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 12:40 p.m. to 2:15 p.m. on 02/17/25, the fire alarm system circuit breaker located in the wall mounted electrical panel identified as "Life Safety Panel" in the Electrical Room near the employee breakroom was not identified as "FIRE ALARM CIRCUIT", did not have a red marking and was not accessible | K 0341 | K341<br>**K341- Fire Alarm System – Installation**<br>**Date of Compliance 2/25/2025**<br><br>**Immediate intervention**<br><br>The Fire Panel breaker located in the Director of plant Operations office had a breaker lock placed on it as well as a label on the outside of the breaker box to identify its location. This corrects the deficiency that had the potential to affect all residents and staff.<br>The Director of plant operations was educated by Regional Support on K341 Fire Alarm System Installation as it pertains to NFPA 70, National Electric code and NFPA72 National Fire alarm code referencing sections 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 and Signaling code section 10.10.1, 10.10.3: 10.10.7.<br>The Director of Plant Operation will visually inspect the fire panel breaker weekly x3 months to ensure fire panel breaker is locked | 02/25/2025 |

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| | to authorized personnel only. The circuit breaker was identified as "Main FACP". Neither the circuit breaker, electrical panel nor the door to the Electrical Room was locked. Based on interview at the time of the observations, the DPO stated the door to the Electrical Room is only locked at night and agreed the fire alarm system circuit breaker was not properly identified and was not accessible only to authorized personnel.<br><br>These findings were reviewed with the Executive Director, the DPO and the Facilities Management Support during the exit conference.<br><br>3.1-19(b) | | and not accessible to unauthorized personnel.<br>This had the potential to affect 56 residents.<br>Results of these audits will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.<br><br>**(Exhibit E) Fire Panel Breaker photo**<br>**(Exhibit F) Fire Panel Breaker Box Label photo** | |
| K 0355 SS=E Bldg. 01 | NFPA 101<br>Portable Fire Extinguishers<br><br>Based on observation and interview, the facility failed to ensure 1 of 16 portable fire extinguishers had the date of 6-year maintenance documented on the extinguisher in accordance with NFPA 10. NFPA 10, 2010 Edition, Section 7.3.1.1.2 states fire extinguishers shall be internally examined at intervals not exceeding those specified in Table 7.3.1.1.2. Section 7.3.1.2.1 states every six years, stored pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable internal examination procedure as detailed in the manufacturer's service manual and this standard. Sections 7.3.3.1 through 7.3.3.2 state fire extinguishers that pass the applicable 6-year requirement shall have the maintenance information recorded on a durable weatherproof label that is a minimum size of 2 inches by 3.5 inches. The label shall be affixed to | K 0355 | **K355**<br><br>**Compliance Date 2/25/2025**<br><br>Portable Fire extinguishers<br><br>**Immediate intervention**<br>Director of Plant Operations removed out of date extinguisher and replaced it with a certified extinguisher and contacted vendor to perform testing on extinguisher in accordance with section 7.3.1.1.2 NFPA 10<br><br>Director of Plant Operations was educated by Executive Director on K355 portable fire extinguishers | 02/25/2025 |

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| | the shell and shall include the month and year the maintenance was performed. The label shall include the initials of the person performing the maintenance and the name of the agency performing the maintenance. A verification of service collar shall be located around the neck of the container indicating the month and year of service and the name of the agency performing the maintenance or recharge. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Work Room near the main entrance lobby to the health care portion of the facility.<br><br>Findings include:<br><br>Based on observations with the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 12:40 p.m. to 2:15 p.m. on 02/17/25, the wall mounted ABC type portable fire extinguisher installed in the corridor near the Work Room near the main entrance lobby was manufactured in 2003 and had a 6-year maintenance collar affixed to the container by the inspection contractor which was dated January 2020. The fire extinguisher inspection contractor had also affixed a 6-year maintenance sticker on the back of the extinguisher documenting 6-year maintenance was performed in May 2015 which was not within the most recent 6-year maintenance period. A January 2020 6-year maintenance sticker was not affixed to the container. Based on interview at the time of the observations, the DPO agreed the aforementioned portable fire extinguisher did not have 6-year maintenance properly documented on the extinguisher with the sticker indicating 6-year maintenance was performed within the most recent 6-year maintenance period. | | NFPA 101. 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, NFPA10.<br><br>Director of Plant Operations will verify annual inspection in accordance with NFPA10, once per month X6.<br><br>This had the potential to affect over 10 residents, staff and visitors.<br><br>The Executive Director will present results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved. Exibit G Fire Extinguisher photo | |

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| | These findings were reviewed with the Executive Director, the DPO and the Facilities Management Support during the exit conference.<br><br>3.1-19(b) | | | |
| K 0363<br>SS=E<br>Bldg. 01 | NFPA 101<br>Corridor - Doors<br><br>Based on observation and interview, the facility failed to ensure 1 of over 35 corridor doors to resident sleeping rooms had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 12 residents, staff and visitors in the vicinity or resident sleeping Room 108.<br><br>Findings include:<br><br>Based on observations with the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 12:40 p.m. to 2:15 p.m. on 02/17/25, the corridor door to resident sleeping Room 108 had an impediment to closing and latching into the door frame when tested to close multiple times. The resident bed nearest the corridor door had been repositioned in the room such that the foot of the resident bed protruded into the path of the swing of the door when attempting to close the door and latch it into the door frame. Based on interview at the time of the observations, the DPO stated the resident bed in the room is not supposed to be oriented the way it currently is, the resident family repositioned the bed in the room and agreed the aforementioned corridor door had an impediment to closing and latching into the door frame and would not resist the passage of smoke with the resident bed oriented with the foot of the bed in | K 0363 | **K363- Corridor - Doors**<br><br>Compliance Date 2/18/2025<br>**Immediate Intervention**<br><br>The DPO removed the residents bed that was blocking the door from closing properly and place it in its original location to prevent it from being an obstruction.<br><br>The Director of Plant Operations was educated by the Executive Director on NFPA 101 Corridor – Doors. Doors protecting corridor openings in other that required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 ¾ inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Corridor doors have positive latching hardware and have no impediment to closing and latching into the door frame and would resist the passage of smoke.<br><br>The Director of Plant Operations will inspect the facility 1 x per | 02/18/2025 |

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| | the path of the swing of the door to close.<br><br>These findings were reviewed with the Executive Director, the DPO and the Facilities Management Support during the exit conference.<br><br>3.1-19(b) | | month x 3 months for corridor doors that have impediments to closing and latching into the door frame.<br>Results of these inspections will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved<br><br>The deficient practice could affect resident located in Room 108.<br><br>Exhibit H1- Room 108 after bed was moved<br>Exhibit H2-Room 108 after bed was moved | |
| K 0521<br>SS=F<br>Bldg. 01 | NFPA 101<br>HVAC<br><br>Based on record review, observation and interview; the facility failed to ensure all smoke dampers in the facility were inspected and tested at least every year in accordance with NFPA 92A, Standard for Smoke-Control Systems Utilizing Barriers & Pressure Differences, 2009 Edition. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.2 states smoke dampers shall be maintained in accordance with NFPA 105, Standard for Smoke Door Assemblies & Other Opening Protectives. NFPA 105, 2010 Edition, Section 6.5.1 states smoke dampers for dedicated | K 0521 | **K521**<br><br>**HVAC**<br><br>**Compliance Date 3/05/2025**<br><br>**Immediate intervention**<br><br>Director of Plant Operations contact vendor to inspect fire dampers to meet deficiency K521.<br>Director of Plant Operations informed vendor that the three fire dampers were missed on all inspections during the last 12 month period and the work needed | 03/05/2025 |

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| | and non-dedicated smoke control systems shall be inspected and tested in accordance with NFPA 92A, Standard for Smoke-Control Systems Utilizing Barriers and Pressure Differences. NFPA 92A, 2009 Edition, Section 8.6.5.1 states nondedicated systems shall be tested at least annually. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of the fire alarm system inspection contractor's "Fire Alarm System Inspection" documentation dated 02/16/24 and 08/26/24 with the Director of Plant Operations (DPO) and the Facilities Management Support during record review from 9:50 a.m. to 12:40 p.m. on 02/17/25, smoke damper inspection and testing documentation within the most recent twelve month period was not available for review. Based on observations with the DPO and the Facilities Management Support during a tour of the facility from 12:40 p.m. to 2:15 p.m. on 02/17/25, three smoke dampers were noted in HVAC duct work in the attic in the south wall of the health care dining room as observed from the attic access door in the conference room across from the Health Club outside the dining room. Based on interview at the time of the observations, the DPO agreed smoke damper inspection and testing documentation for the most recent twelve month period was not available for review.<br><br>These findings were reviewed with the Executive Director, the DPO and the Facilities Management Support during the exit conference.<br><br>3.1-19(b) | | to be completed asap. March 5th is the earliest they could be on sight.<br><br>The Director of Plant Operations was educated by regional support on NFPA 90A, LSC9.2.1, NFPA 80, 19.4.1.1 as pertains to maintenance and testing of fire dampers and documentation of location, date of inspection, name of inspector, and deficiencies discovered.<br><br>The Director of Plant Operations will maintain documentation of completion and will provide new documentation as per regulation states. The annual inspection has been added to TELS.<br><br>This could affect 56 residents, staff and visitors.<br><br>The Executive Director will present the results of inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved. Exibit I Fire Damper Vendor Scheduled Inspection date | |

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|---|---|---|---|
| | 155762 | A. BUILDING 01<br>B. WING | 02/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| FOREST PARK HEALTH CAMPUS | 2401 SOUTH L ST<br>RICHMOND, IN 47374 |

| (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 |
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| K 0711 SS=C Bldg. 01 | NFPA 101<br>Evacuation and Relocation Plan<br><br>Based on record review and interview, the facility failed to provide a complete written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:<br>(1) Use of alarms<br>(2) Transmission of alarm to fire department<br>(3) Emergency phone call to fire department<br>(4) Response to alarms<br>(5) Isolation of fire<br>(6) Evacuation of immediate area<br>(7) Evacuation of smoke compartment<br>(8) Preparation of floors and building for evacuation<br>(9) Extinguishment of fire<br>This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review with the Director of Plant Operations (DPO) and the Facilities Management Support during record reiew from 9:50 a.m. to 12:40 p.m. on 02/17/25, the written fire safety plan for the facility is contained in "Emergency and Disaster Preparedness Manual" documentation dated 06/14/24. Page 29 of the 06/14/24 documentation stated "if the fire is a significant fire, evacuate all residents, volunteers and staff from the affected compartment to another compartment". The 06/14/24 documentation did not state or identify smoke compartment locations in the facility nor did the 06/14/24 documentation identify the location of smoke or fire barrier doors in the facility. The 06/14/24 documentation did have a tab to include "Floor Plans" in the | K 0711 | K711 – Evacuation and Relocation<br>Compliance Date 2/19/2025<br>Immediate Intervention<br>The Director of Plant Operations updated the fire plan to include locations of the smoke/fire barriers were not addressed on the facility floor plan.<br>The Director of Plant Operations was educated by the Executive Director on K711 – NFPA 101 Evacuation and Relocation Plan.<br>There is a written plan for the protection of all patients and for their evacuation in the event of emergency.<br>The Director of Plant Operations of Plant Operations will audit and update the Fire Plan 1 x per month x 3 months.<br>Results of these audits will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.<br>The deficient practice could affect all occupants.<br>Exibit J Updated Floor Plan | 02/19/2025 |

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| | documentation but no floor plan was located in the 06/14/24 documentation. Based on interview at the time of record review, the DPO provided a floor plan from his Life Safety Code record review book but this floor plan also did not state or identify smoke compartments in the facility. Based on interview at the time of record review, the DPO stated he regularly trains staff on fire drill and evacuation procedures in which he details the location of each smoke compartment but agreed written fire safety documentation for the facility did not state the location of smoke compartments in the facility.<br><br>These findings were reviewed with the Executive Director, the DPO and the Facilities Management Support during the exit conference.<br><br>3.1-19(b) | | | |
| K 0712 SS=C Bldg. 01 | NFPA 101<br>Fire Drills<br><br>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the second shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.<br><br>Findings include:<br><br>Based on review of "Fire Drill Report" documentation with the Director of Plant Operations (DPO) and the Facilities Management Support during record review from 9:50 a.m. to 12:40 p.m. on 02/17/25, second shift fire drills conducted within the most recent twelve month period on 06/20/24, 09/10/24, and 12/16/24 were conducted at, respectively, 2:30 p.m., 2:15 p.m. and | K 0712 | **K712 – Fire drills**<br><br>Compliance Date 2/26/2025<br><br>**Immediate Intervention**<br><br>The Director of Plant Operations A Fire Drill on three shifts with documentation confirming the transmission of the fire alarm to the monitoring company.<br><br>The Director of Plant Operations was educated by the Executive Director on NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and | 02/26/2025 |

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| | 3:10 p.m. Based on interview at the time of record review, the DPO stated the facility operates three shifts per day, additional second shift fire drill documentation was not available for review and agreed the aforementioned second shift fire drills were not conducted at unexpected times under varying conditions.<br><br>These findings were reviewed with the Executive Director, the DPO and the Facilities Management Support during the exit conference.<br><br>3.1-19(b)<br>3.1-51(c) | | simulation of emergency fire conditions. Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. 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.<br><br>The Director of Plant Operations will perform fire drill 1 x per month each shift quarterly with varying times. All documentation will be uploaded and housed in TELS.<br><br>Results of these Fire Drills will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.<br><br>This deficient practice had the potential to affect all staff, resident, and visitors of the facility.<br>Exhibit K Fire Drills | |
| K 0923<br>SS=E<br>Bldg. 01 | NFPA 101<br>Gas Equipment - Cylinder and Container Storag<br>Based on observation and interview, the facility | K 0923 | **K923 Gas Equipment – Cylinder** | 02/25/2025 |

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| | failed to ensure 1 of 1 indoor oxygen storage areas was in accordance with NFPA 99, Health Care Facilities Code. NFPA 99, 2012 Edition, Section 11.3.1 states storage for nonflammable gases equal to or greater than 3000 cubic feet shall comply with 5.1.3.3.2 and 5.1.3.3.3. Section 5.1.3.3.2 states, if indoors, storage locations of positive-pressure gases shall be constructed and use interior finishes of noncombustible or limited combustible materials such that all walls, floor, ceilings, and doors are of minimum 1-hour fire resistant rating. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the oxygen storage room by resident sleeping Room 102.<br><br>Findings include:<br><br>Based on observations with the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 12:40 p.m. to 2:15 p.m. on 02/17/25, two separate one inch in diameter holes were noted in the east wall of the oxygen storage and transfilling room by resident sleeping Room 102 which did not enclose the room with a minimum 1-hour fire resistant rating. Seven oxygen containers and eleven oxygen cylinders were stored in the oxygen storage and transfilling room. A metal storage rack was laying on top of one of the oxygen containers in the room. Based on interview at the time of the observations, the DPO stated the metal storage rack used to be installed on the east wall of the room but it became disconnected from the wall which caused the holes in the wall. The DPO agreed the holes in the wall where the metal storage rack had been installed did not enclose the room with a minimum 1-hour fire resistant rating. | | **and Container Storage**<br>Compliance Date 2/25/2025<br>**Immediate Intervention**<br>The Director of Plant Operations removed the metal storage bracket from the floor and repaired the two screw holes in the wall with proper fire caulk to repair the wall back to proper fire rated condition.<br>The Director of Plant Operations was educated by the Executive Director on Gas Equipment – Cylinder Container Storage 5.1.3.3.2 and 5.1.3.3.3. In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of = 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. | |

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| | These findings were reviewed with the Executive Director, the DPO and the Facilities Management Support during the exit conference.<br><br>3.1-19(b) | | 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)<br>The Director of Plant Operations will audit the oxygen storage rooms for proper storage of oxygen 1 x per week x 3 months. Results of these exercises will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect over 20 residents, staff and visitors. Exhibit L O2 Room photo after repairs were done. | |