STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING -- B. WING	04/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

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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: 04/20/22 Facility Number: 012548 Provider Number: 155790 AIM Number: 201023760 At this Emergency Preparedness survey, Bridgewater Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare Providers and Suppliers, 42 CFR 483.73 The facility has 120 certified beds. At the time of the survey, the census was 75. Quality Review completed on 04/26/22	E 0000		
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: 04/20/22 Facility Number: 012548 Provider Number: 155790 AIM Number: 201023760 At this Life Safety Code survey, Bridgewater Healthcare Center was found not in compliance	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	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 Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 120 and had a census of 75 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached building for medical gas storage and the generator transfer switch which was not accessible during this survey - the key could not be found. Quality Review completed on 04/26/22		cited during the facility's Life Safety Code with Emergency Preparedness Survey. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be			

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	permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall			

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	be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 1. Based on observation and interview, the facility failed to ensure all means of egress was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 15, staff and visitors if needing to exit the facility. Findings include: Based on observation and interview on 04/20/22 between 11:50 a.m. and 3 p.m. with the Maintenance Director (MD) during a tour of the facility, the exit door from the Shipping and receiving area was marked as a facility exit, was magnetically locked and could be opened by entering a four-digit code but the code was not posted at the exit. This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Interim Administrator, Maintenance Director, Corporate Director of	K 0222	**K222-Egress Doors** **What corrective actions have been accomplished for those residents found to have been affected by the deficient practice;** 1. The four-digit code was posted at the shipping and receiving area exit. 2. SafeCare is to repair the egress door 5/05/2022; work order #109049. 3. The kitchen exit door was repaired. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** All residents have the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure**	05/16/2022

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	Clinical Solutions and the Director of Operations present at the 3:30 p.m. exit conference. 2. Based on observation and Interview, the facility failed to ensure 1 of 1 delayed egress locking arrangements in the 600 hall was installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect 4 staff. Findings include: Based on observation and interview on 04/20/22 between 11:50 a.m. and 3 p.m. with the Maintenance Director (MD) during a tour of the facility, the employee break room exit door was equipped with a 15 second delayed egress. When the exit doors were tested the irreversible process to release the lock was not initiated. Multiple attempts to activate the delayed egress mechanism failed. This finding was acknowledged by the		**that the deficient practice does not recur;** The Maintenance Director is to monitor egress doors weekly and report any malfunctions to the Executive Director/designee immediately for repair. **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** Results of the audit will be brought to QAPI for six months or until 100% compliance is achieved. **By what date the systemic changes for each deficiency will be completed;** Changes will be implemented by May 16th, 2022.	

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	Maintenance Director at the time of discovery and again with the Interim Administrator, Maintenance Director, Corporate Director of Clinical Solutions and the Director of Operations present at the 3:30 p.m. exit conference. 3. Based on observation and interview, the facility failed to ensure all exit doors were readily accessible and able to open on first try. This deficient practice could affect at least 5 to 10 occupants in the kitchen. Findings include: Based on observation and interview on 04/20/22 between 11:50 a.m. and 3 p.m. with the Maintenance Director (MD) during a tour of the facility, kitchen had an exit door which would not open when tested. The Maintenance Director stated that the hardware was broken and would need to be replaced. This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Interim Administrator, Maintenance Director, Corporate Director of Clinical Solutions and the Director of Operations present at the 3:30 p.m. exit conference. 3.1-19(b)			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an			

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	automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure all 11 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 30 residents, as well as staff and visitors. Findings include: Based on observation and interview on 04/20/22 between 11:50 a.m. and 3 p.m. with the	K 0321	**K321-Hazardous Areas - Enclosure** **What corrective actions have been accomplished for those residents found to have been affected by the deficient practice;** 1. Rooms 4003, 4004, 4005, 4006, 4007, 4008, 4009, 4021, and 4023, have been emptied of all stored equipment, mattresses,	05/16/2022

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	Maintenance Director (MD) during a tour of the facility, the following was noted: A) Room 4003, greater than 50 square feet, contained a number of combustible items, such as 6 mattresses and several chairs. The corridor door to this room was not equipped with a self-closing device. B) Room 4005 & 4007, greater than 50 square feet, had storage of Christmas decorations and boxes. The room doors were not equipped with a self-closing device or self-closing hinges. C) Room 4009, greater than 50 square feet, had several beds, boxes and random pieces of furniture stored inside the room. The room door was not equipped with a self-closing device or self-closing hinges. D) Room 4021, greater than 50 square feet, had Christmas tree boxes and other combustible items stored inside the room. The room door was not equipped with a self-closing device or self-closing hinges. E) Room 4023, greater than 50 square feet, had more than 50 empty plastic yellow linen storage containers and other combustible items stored inside the room. The room door was not equipped with a self-closing device or self-closing hinges. F) Rooms 4008 & 4006, greater than 50 square feet, had Christmas tree boxes and other combustible items stored inside the room. The room doors were not equipped with a self-closing device or self-closing hinges. G) Room 4004, greater than 50 square feet,		Christmas décor, boxes and random furniture. These rooms have been set up with appropriate furnishings to accommodate potential residents. 2. Self-closing devices have been placed on rooms 4001 and Staff Development's doors. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** All potential residents on the 4000 hallhas potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance Director is to audit 6 rooms per week on the 4000 hall. Staff to be educated. **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** Results of the audit will be brought to QAPI for six months or until 100% compliance is achieved. **By what date the systemic changes for each deficiency will be completed;** Changes will be implemented by	

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	racks of clothes stored inside the room. The room door was not equipped with a self-closing device or self-closing hinges. H) Room 4001, greater than 50 square feet, had over 30 one-gallon paint cans and 18 five gallon paint containers, 8 large totes and other combustible items stored inside the room. The room door was not equipped with a self-closing device or self-closing hinges. I) The Staff Development Office, greater than 50 square feet, had more than 26 large cardboard boxes and other combustible items stored inside the room. The room door was not equipped with a self-closing device or self-closing hinges. These findings were acknowledged by the Maintenance Director at the time of discovery and again with the Interim Administrator, Maintenance Director, Corporate Director of Clinical Solutions and the Director of Operations present at the 3:30 p.m. exit conference. 3.1-19(b)		May 16th, 2022.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in			

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	smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 1. Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchen. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect staff in the kitchen and 25 residents in the dining room. Findings include: Based on observation and interview on 04/20/22 between 11:50 a.m. and 3 p.m. with the Maintenance Director (MD) during a tour of the facility, the kitchen contained a UL 300 hood system and a K-class fire extinguisher with posted instructions. Based on interview, a random kitchen staff member was asked; what is the correct response if there was a grease fire underneath the hood. The employee replied, use the k-class extinguisher. The employee failed to indicate activating the UL 300 hood extinguishing system for a hood grease fire. When asked when they would use the UL 300 Hood System the employee responded, when there was a fire in the entire kitchen, wiring and	K 0324	**K324-Cooking Facilities** **What corrective actions have been accomplished for those residents found to have been affected by the deficient practice;** 1. Dietary staff educated on the proper use of the UL 300 hood system. 2. Therapy staff to be educated. 3. Both cooktops in the two therapy areas are to be shut off at a switch located in the cabinet above the cooktop when not in use. Switches have deadbolt locks. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** All residents have the potential to be affected. **What measures will be put into**	05/16/2022

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	the like. The Maintenance Director acknowledged the employee's response and stated all kitchen staff will be informed on proper response. This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Interim Administrator, Maintenance Director, Corporate Director of Clinical Solutions and the Director of Operations present at the 3:30 p.m. exit conference. 2. Based on observation and interview, the facility failed to ensure the cook tops in the two Therapy areas were shut off at the switch when not in use. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect five residents		**place and what systemic changes will be made to ensure that the deficient practice does not recur;** Executive Director is to monitor cooktops five times per week for 8 weeks or until 100% compliance. **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** Results of the audit will be brought to QAPI for six months or until 100% compliance is achieved. **By what date the systemic changes for each deficiency will be completed;** Changes will be implemented by May 16th, 2022.	

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	in the therapy areas. Findings include: Based on observation and interview on 04/20/22 between 11:50 a.m. and 3 p.m. with the Maintenance Director (MD) during a tour of the facility, there was a cooktop in each of two therapy areas that was separated from the corridor, but when checked and not in use each appliance was not deactivated from the cooktop power source. Based on interview at the time of observation, the Maintenance Director was asked if staff knew to deactivate the cooktop when not in use and lock the switch? The MD stated he was not sure. This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Interim Administrator, Maintenance Director, CorporateDirector of Clinical Solutions and the Director of Operations present at the 3:30 p.m. exit conference. 3.1-19(b)			
K 0351 SS=C Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific			

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	areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility did not provide adequate signage for 1 of 1 fire department connection (FDC). NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, 13.7 Fire Department Connections. 13.7.1 Fire department connections shall be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. This deficient practice could affect all residents. Findings include: Based on observation and interview on 04/20/22 between 11:50 a.m. and 3 p.m. with the Maintenance Director (MD) during a tour of the facility, the FDC (painted silver) located to the	K 0351	**K351-Sprinkler System Installation** **What corrective actions have been accomplished for those residents found to have been affected by the deficient practice;** Proper signage for the FDC located to the left of the parking lot entrance was obtained. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** All residents have the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Maintenance Director is to monitor signage weekly. **How the corrective action will be monitored to ensure the**	05/16/2022

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	left of the parking lot entrance, was not provided with a FDC identification sign. Based on interview at the time of observation, the MD agreed there was no identification sign on the FDC. This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Interim Administrator, Maintenance Director, Corporate Director of Clinical Solutions and the Director of Operations present at the 3:30 p.m. exit conference. 3.1-19(b)		**deficient practice will not recur, what quality assurance program will be put into place;** Results of the monitoring will be brought to QAPI for six months or until 100% compliance is achieved. **By what date the systemic changes for each deficiency will be completed;** Changes will be implemented by May 16th, 2022.	
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 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			

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	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.			
	1. Based on observation and interview, the facility failed to ensure all corridor doors would resist the passage of smoke. This deficient practice could affect 2 residents. Findings include: Based on observation and interview on 04/20/22 between 11:50 a.m. and 3 p.m. with the Maintenance Director (MD) during a tour of the facility, the corridor door to Resident room 4001 had one hole approximately ½ inch in diameter which penetrated completely through the door: This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Interim Administrator, Maintenance Director, Corporate Director of Clinical Solutions and the Director of Operations present at the 3:30 p.m. exit	K 0363	**K363-Corridor - Doors** **What corrective actions have been accomplished for those residents found to have been affected by the deficient practice;** 1. The door to room 4001 has been repaired. 2. The door to room 5008 has been repaired. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** All residents have the potential to be affected. **What measures will be put into place and what systemic**	05/16/2022

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	conference. 2. Based on observation and interview, the facility failed to ensure all resident room corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents. Findings include: Based on observation and interview on 04/20/22 between 11:50 a.m. and 3 p.m. with the Maintenance Director (MD) during a tour of the facility, the corridor door to resident room 5008 did not latch into the frame when tested. The door had a side piece which received the main door, the ability of the two doors to work as engineered appeared to need repair, preventing the two doors from forming a smoke-tight enclosure when in the closed position. This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Interim Administrator, Maintenance Director,Corporate Director of Clinical Solutions and the Director of Operations present at the 3:30 p.m. exit conference. 3.1-19(b)		**changes will be made to ensure that the deficient practice does not recur;** The Maintenance Director is to monitor six resident doors weekly. **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** Results of the monitoring will be brought to QAPI for six months or until 100% compliance is achieved. **By what date the systemic changes for each deficiency will be completed;** Changes will be implemented by May 16th, 2022.	
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			

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	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 and interview, the facility failed to ensure all wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B) (1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for	K 0511	**K511-Utilities – Gas and Electric** **What corrective actions have been accomplished for those residents found to have been affected by the deficient practice;** A GFCI has been installed for the water and juice machine located in the serving area on the 4000 hall. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** The 4000 Hall is closed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Maintenance Director will ensure a GFCI is installed prior to any new equipment located in a wet location. **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** Installation of new equipment	05/16/2022

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	only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff and up to 4 residents. Findings include: Based on observation and interview on 04/20/22 between 11:50 a.m. and 3 p.m. with the Maintenance Director (MD) during a tour of the facility, the serving area adjacent to the dining hall on the 4000 hall had a water and juice machine, with their own water source, connected		located in a wet location will be reported to QAPI for one year. **By what date the systemic changes for each deficiency will be completed;** Changes will be implemented by May 16th, 2022.	

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	to an electric receptacle which was being used to power the freestanding machines which was not GFCI protected. The machines were located within 3 feet of the electric receptacle, and not provided with ground fault circuit interruption (GFCI). This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Interim Administrator, Maintenance Director, Corporate Director of Clinical Solutions and the Director of Operations present at the 3:30 p.m. exit conference. 3.1-19(b)			
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 fire drills or documented orientation training on 2 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under	K 0712	**K712-Fire Drills** **What corrective actions have been accomplished for those residents found to have been affected by the deficient practice;** The maintenance director will	05/16/2022

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	varied conditions. QSO-20-31 1135 temporary waiver states in lieu of a physical fire drill, a documented orientation training program related to the current fire plan, which considers current facility conditions, is acceptable. The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area. This deficient practice affects all staff and patients. Findings include: Based on interview and record review on 04/20/22 between 9:40 a.m. and 11:50 a.m. with the Maintenance Director (MD), the following shifts were missing documentation of a completed fire drill or documented orientation training: a) Third shift in the first or fourth quarter of 2021 or 2022. b) Second shift in the second and fourth quarter of 2021. Based on interview at the time of record review, the MD agreed there were four missing fire drills and staff has not been trained in the fire safety procedures for the first, second or fourth quarters. This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Interim Administrator, Maintenance Director, Corporate Director of Clinical Solutions and the Director of Operations present at the 3:30 p.m. exit conference. 3.1-19(b) 3.1-51(c)		conduct fire drills quarterly on each shift. Staff to be educated. The Human Resources Manager/designee will audit all new employee files for documented orientation training. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** All residents have the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Executive Director will audit fire drill records monthly for six months. **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** Results of the audit will be brought to QAPI for six months or until 100% compliance is achieved. **By what date the systemic changes for each deficiency will be completed;** Changes will be implemented by May 16th, 2022.	

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K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on observation, records review, and interview, the facility failed to enforce 1 of 1 non-smoking policies. This deficient practice could affect staff around the service exit. Findings include: Based on observation and interview on 04/20/22	K 0741	**K741-Smoking Regulations** **What corrective actions have been accomplished for those residents found to have been affected by the deficient practice;** All staff have been in-serviced on	05/16/2022

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	between 11:50 a.m. and 3 p.m. with the Maintenance Director (MD) during a tour of the facility, smoking on property was evident due to at least 100 plus cigarette butts on the ground around the shipping and receiving exit near the generator building. Along the drive, the curb and in the greenspace, multiple cigarette butts were observed on the ground. Based on records review the smoking policy stated smoking is not allowed on the facility's property. This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Interim Administrator, Maintenance Director, Corporate Director of Clinical Solutions and the Director of Operations present at the 3:30 p.m. exit conference. 3.1-19(b)		the facility's smoking policy. Evidence of smoking has been removed from areas identified during Life Safety facility tour. New staff will be educated on the facility smoking policy upon hire. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Human Resource Manager will audit five employee files once a week for 8 weeks, then five employee files once a month for six months. **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** Results of the audit will be brought to QAPI for six months or until 100% compliance is achieved. **By what date the systemic changes for each deficiency will be completed;** Changes will be implemented by May 16th, 2022.	
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			

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	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 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 record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing at all resident rooms was available for review in accordance with NFPA 99. 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 shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. 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	K 0914	**K914-Electrical Systems – Maintenance and Testing** **What corrective actions have been accomplished for those residents found to have been affected by the deficient practice;** The maintenance director will ensure all electrical outlet receptacles in resident rooms are tested within a 12 month period. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** All residents have the potential to	05/16/2022

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	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). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all residents. Findings include: Based on interview and record review on 04/20/22 between 9:40 a.m. and 11:50 a.m. with the Maintenance Director (MD), an itemized listing of inspection and testing electrical outlet receptacles within the most recent twelve-month period was not available for review. Furthermore, no documentation of receptacle testing prior to January 2020 and the onset of the COVID-19 Pandemic were available for review. Based on observations during a tour of the facility each resident room contained multiple electrical receptacles installed near resident bed locations. This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Interim Administrator, Maintenance Director, Corporate Director of Clinical Solutions and the Director of Operations present at the 3:30 p.m. exit conference. 3.1-19(b)		be affected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Executive Director will audit 6 tests results a month for 12 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** Results of the audit will be brought to QAPI for six months or until 100% compliance is achieved. **By what date the systemic changes for each deficiency will be completed;** Changes will be implemented by May 16th, 2022.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was	K 0918	**K918-Electrical Systems – Essential Electric Systems**	05/16/2022

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	155790	A. BUILDING 01 B. WING	04/20/2022

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	equipped with a properly located remote stop in the event the generator caught fire. NFPA 110, Standard for Emergency and Standby Power Systems 2010 Edition, Section 5.6.5.6, requires all installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. Section 5.6.5.6.1, requires the remote manual stop station to be labeled. Annex A is not a part of the requirements but is included for informational purposes only. A.5.6.5.6 states for systems located outdoors, the manual shutdown should be located external to the weatherproof enclosure and should be appropriately identified. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on observation and interview on 04/20/22 between 11:50 a.m. and 3 p.m. with the Maintenance Director (MD) during a tour of the facility, the generator was not equipped with an emergency stop button which could be located. The door to the remotely located generator room was locked and a key could not be located. Based on interview at the time of observation, the MD agreed the location of the emergency stop button was uncertain and access to the generator room was not provided. This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Interim Administrator, Maintenance Director, Corporate Director of		**What corrective actions have been accomplished for those residents found to have been affected by the deficient practice;** Access to the Generator Room where the emergency stop button is located was obtained. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** All residents have the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Maintenance Director is to monitor location of Generator Room key once a week. **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** Results of the monitoring will be brought to QAPI for six months or until 100% compliance is achieved. **By what date the systemic changes for each deficiency will be completed;**	

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	Clinical Solutions and the Director of Operations present at the 3:30 p.m. exit conference. 3.1-19(b)		Changes will be implemented by May 16th, 2022.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically	K 0920	**K920-Electrical Equipment – Power Cords and Extensions** **What corrective actions have been accomplished for those residents found to have been**	05/16/2022

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	permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 3 residents on the Salon. Findings include: Based on observation and interview on 04/20/22 between 11:50 a.m. and 3 p.m. with the Maintenance Director (MD) during a tour of the facility, the following locations had (high power draw equipment) connected to power strips; a) In the entry lobby near the window, a refrigerator. b) In the entry lobby near the reception desk, a coffee machine. c) In the Rehab Managers Office, a refrigerator. This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Interim Administrator, Maintenance Director, Corporate Director of Clinical Solutions and the Director of Operations present at the 3:30 p.m. exit conference. 3.1-19(b)		**affected by the deficient practice;** a) The refrigerator located in the entry lobby has been relocated and is plugged into an electrical wall receptacle. b) The coffee machine located in the entry lobby has been relocated to be plugged into an electrical wall receptacle. c) The refrigerator located in the Rehab Manager's office is plugged into an electrical wall receptacle. Staff to be educated. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** All residents have the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Maintenance Director is to monitor facility power strips to ensure no power high power equipment is plugged into power strips monthly. **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;**	

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			Results of the monitoring will be brought to QAPI for six months or until 100% compliance is achieved. **By what date the systemic changes for each deficiency will be completed;** Changes will be implemented by May 16th, 2022.	