STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155786	A. BUILDING -- B. WING	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(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 Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/18/23 Facility Number: 012466 Provider Number: 155786 AIM Number: 201014060 At this Emergency Preparedness survey, Allisonville Meadows was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 161 certified beds. At the time of the survey, the census was 107. Quality Review completed on 01/23/23	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: 01/18/23 Facility Number: 012466 Provider Number: 155786 AIM Number: 201014060 At this Life Safety Code survey, Allisonville Meadows was found not in compliance with	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shane McFall	Executive Director	02/03/2023

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

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	Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety From Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 161 and had a census of 107 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 01/23/23			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 2 of 7 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 20 residents, staff and visitors if	K 0211	A. The portable wheelchair scale was moved out of the path of the exit access/exit door by the Maintenance Director 1/18/2023. B. All Egress doors were checked for obstruction 1/18/2023.	02/18/2023

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	needing to exit the facility. Findings include: Based on observations with the Maintenance Director during the initial walk through of the facility from 9:15 a.m. to 9:30 a.m. on 01/18/23, a portable wheelchair weigh scale was stored in the corridor outside resident sleeping Room 530 in the path of the exit access for the exit door to the outside of the facility in the 500 Hall. The weigh scale was stored within two feet of the exit door and blocked half of the width of the exit door. The Maintenance Director removed the weigh scale from the exit access at the time of the observations. In addition, cardboard boxes were stored up against the wall on one side of the service hall corridor and at least eight portable meal tray serving carts were stored along the opposite side of the corridor up against the service hall corridor wall which reduced the clear and unobstructed width of the service hall corridor to three feet. Based on observations with the Maintenance Director at 2:10 p.m. on 01/18/23, the cardboard boxes and meal tray serving carts were still stored in the service hall corridor which reduced the clear and unobstructed width of the service hall corridor to three feet. The 400 Hall exit door set leading to the service hall corridor was marked as a facility exit with an exit sign. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned means of egress was not continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		C. The Daily Survey Observation tool will be utilized by the Maintenance Director/designee to ensure means of egress are clear. D. The Life Safety POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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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 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			

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	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 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 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 7 exits were 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 Section 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 20 residents, staff and visitors if needing to exit the facility from the 400 Hall. Findings include:	K 0222	A. The Maintenance Director updated door exit codes for 5/5 exit doors identified. The posted codes for 5/5 doors were updated 1/18/2023. B. Exit Door Codes to be updated monthly by the Maintenance Supervisor. Exit Door codes will be posted with updated codes monthly by the Maintenance Supervisor. C. The Maintenance Director/designee will update Exit	02/18/2023

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	Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:15 p.m. on 01/18/23, the exit door set in the 400 Hall serving as the entrance to the service hall was marked as a facility exit with an exit sign and could be opened by entering a code into a keypad at the door. However, the code was not posted at the exit door. Based on interview at the time of the observations, the Maintenance Director agreed the keypad code to release the exit door set to open was not posted at the keypad. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		door codes and posted codes for all exit doors on the first business day of the month. Posted codes will be ensured by completing Daily survey monitoring tool. D. The Life Safety POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			

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	Based on record review, observation and interview; the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all kitchen staff and visitors in the facility. Findings include: a. Based on review of the sprinkler system inspection contractor's "Form for Inspection, Testing and Maintenance of Dry Pipe Fire Sprinkler Systems" documentation dated 07/13/20 with the Maintenance Director during record review from 9:30 a.m. to 12:10 p.m. on 01/18/23, dry sprinklers in the exterior canopy need to be replaced. The 07/13/20 inspection report stated twelve dry sprinklers in the exterior canopy need to be replaced. Based on interview at the time of record review, the Maintenance Director stated he was not aware if the dry sprinklers in the exterior canopy had been replaced and agreed documentation of dry sprinkler replacement on or after 07/13/20 was not available for review. Review of e-mail documentation to the facility	K 0353	A. The 12 dry sprinklers in the exterior canopy will be replaced, vendor contracted and work order scheduled. Tyco accelerator- recovered documentation demonstrated repairs were in place prior to the date of the survey. B. Maintenance Director and ED to review most recent sprinkler testing reports for completion 1/18/2023. C. Maintenance Director was provided training to ensure that inspection results are addressed timely. The ED/Maintenance Director will request repairs to sprinkler system after testing reports are received. Follow up on testing reports will continue until areas of concern identified are repaired. D. Life Safety POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	02/18/2023

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	from the sprinkler system inspection contractor dated 01/18/23 indicated "(2) quotes were sent to replace canopy heads - last quote was in December 2020. If they have been replaced, we did not replace them as we never received approval". b. Based on review of the sprinkler system inspection contractor's "Form for Inspection, Testing and Maintenance of Dry Pipe Fire Sprinkler Systems" documentation dated 07/21/22 with the Maintenance Director during record review from 9:30 a.m. to 12:10 p.m. on 01/18/23, dry sprinkler system's quick opening devices did not pass testing. The "Deficiency Summary" section of the 07/21/22 inspection report stated (1) tyco accelerator quick opening device could not be reset but it did not specifically state which one of the two dry sprinkler systems quick opening devices could not be reset. Based on interview at the time of record review, the Maintenance Director stated he was not aware if the dry sprinkler's quick opening devices had been reset or had been repaired or replaced and agreed documentation of dry sprinkler system quick opening devices repair or replacement on or after 07/21/22 was not available for review. Review of e-mail documentation to the facility from the sprinkler system inspection contractor dated 01/18/23 indicated "this was quoted on 08/03/22 and was never approved". Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:15 p.m. on 01/18/23, the facility has two supervised dry sprinkler systems with two separate accelerators and one supervised wet sprinkler system. These findings were reviewed with the Maintenance Director during the exit conference.			

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	3.1-19(b)			
K 0362 SS=E Bldg. 01	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 Based on observation and interview, the facility failed to ensure corridor walls in 1 of 7 smoke compartments in the facility were constructed to resist the transfer of smoke. This deficient practice could affect over 15 residents, staff and visitors in the 200 Hall. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:15 p.m. on 01/18/23, a ten inch long by	K 0362	A. Drywall barrier with fire caulking to cover open metal grate scheduled to be completed. B. All walls were inspected for metal grates that would not resist the passage of smoke. C. Drywall barrier with fire caulking to cover open metal grate ordered to be completed. D. The Life Safety POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and	02/18/2023

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	five inch high open metal grate was noted in the corridor wall above the corridor door to the 200 Hall Activities Storage Room which would not resist the passage of smoke. Based on interview at the time of the observations, the Maintenance Director agreed the opening in the corridor wall would not resist the passage of smoke. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	
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 closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of			

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	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 1 of over 50 corridor doors were equipped with positive latching hardware, had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:15 p.m. on 01/18/23, the corridor door to the kitchen from the service hall by the exit door set in the 400 Hall was not equipped with positive latching hardware. The door was equipped with a deadbolt lock which required a key to unlock from the corridor side of the door and had a thumb twist release on the room side of the door. The door was not locked at the time of the observations. The door was in the partially open position with a two inch gap in between the face of the door and the door stop on the door frame on the handle side of the door. Based on	K 0363	A. Positive latching hardware was ordered for the corridor entry to the kitchen. B. All doors in the facility were checked for latching1/18/2023. C. Positive latching hardware was ordered for the corridor entry to the kitchen. D. The Life Safety POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	02/18/2023

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	interview at the time of the observations, the Maintenance Director agreed the corridor door to the kitchen from the service hall by the exit door set in the 400 Hall was not equipped with positive latching hardware which did not ensure the door would close and latch into the door frame to resist the passage of smoke. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)			
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review and interview, the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. 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 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. The test and inspection frequency shall be every 4 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked	K 0521	**A.** Fire Dampers identified as failed will be repaired/ replaced, vendor contacted and work order scheduled. **B.** Dampers inspected per schedule throughout the building 1/18/2023. **C.** Fire Dampers identified as failed will be repaired/replaced, vendor contacted and work order scheduled. **D.** The Life Safety POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the	02/18/2023

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

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	from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the fire damper inspection contractor's "Fire/Smoke Damper Maintenance Record" documentation dated 09/23/19 with the Maintenance Director during record review from 9:30 a.m. to 12:10 p.m. on 01/18/23, it could not be assured all facility fire dampers which failed inspection and testing within the most recent four year period were repaired or replaced. At least 16 fire dampers were listed as failing inspection and testing on the 09/23/19 documentation. Based on interview at the time of record review, the Maintenance Director stated fire damper repair or replace documentation on or after 09/23/19 was not available for review. Review of e-mail documentation to the facility from the fire alarm system inspection contractor dated 01/18/23 stated "quote was sent to facility on 12/10/19 to repair dampers that failed inspection. Quote was never approved". Based on interview at the time of review of the e-mail documentation, the Maintenance Director stated the fire alarm system inspection contractor subcontracted fire damper inspections to a subcontractor who performed the 09/23/19 inspection and testing and agreed fire damper repair or replace documentation on or after 09/23/19 was not available for review at the time of the survey. This finding was reviewed with the Maintenance		Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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	Director during the exit conference. 3.1-19(b)			
K 0524 SS=E Bldg. 01	NFPA 101 HVAC - Direct-Vent Gas Fireplaces Direct-Vent Gas Fireplaces Direct-vent gas fireplaces, as defined in NFPA 54, inside of all smoke compartments containing patient sleeping areas comply with the requirements of 18.5.2.3(2), 19.5.2.3(2). 18.5.2.3(2), 19.5.2.3(2), NFPA 54 Based on record review, observation and interview; the facility failed to ensure 1 of 1 direct-vent fireplaces was protected with carbon monoxide detection. LSC 19.5.2.3 (2)(f) states electrically supervised carbon monoxide detection in accordance with Section 9.8 shall be provided in the room where the fireplace is located. This deficient practice could affect over 10 residents, staff and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Fire Alarm Supplementary Form" documentation dated 01/21/22, 07/14/22 and 01/03/23 with the Maintenance Director during record review from 9:30 a.m. to 12:10 p.m. on 01/18/23, carbon monoxide detectors in the facility were not listed as visually inspected or tested within the most recent twelve month period. Review of e-mail documentation to the facility from the fire alarm system inspection contractor dated 01/18/23 indicated the carbon monoxide alarm on the fireplace in the main entry area "is a stand alone unit and we do not test it. We only test items tied to the fire alarm panel". Based on observations with the Maintenance Director during a tour of the	K 0524	**A.** Carbon Monoxide alarm identified as stand alone will be replaced with electrically supervised Carbon Monoxide alarm. Replacement detectors contracted to be completed. **B.** All carbon monoxide alarms checked to ensure they are electrically supervised 1/18/2023. **C.** Carbon Monoxide alarm identified as stand alone will be replaced with a electrically supervised Carbon Monoxide alarm. **D.** The Life Safety POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	02/18/2023

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	facility from 12:50 p.m. to 3:15 p.m. on 01/18/23, resident sleeping rooms 101 through 108 are in the same smoke compartment that the main entrance lobby is in. A natural gas fired direct-vent fire place was noted in the main entrance lobby. A carbon monoxide detector was installed on the wall by the fire place in the main entrance lobby but it appeared to be a battery operated stand alone unit not wired to fire alarm system. Based on interview at the time of the observations, the Maintenance Director agreed the main entrance lobby was not equipped with electrically supervised carbon monoxide detection. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)			
K 0761 SS=F Bldg. 01	Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies	K 0761	**K761 Maintenance, Inspection, & Testing- Doors** **A.** All fire doors will be labeled in the "Fire-Smoke Doors: Annual Fire/Smoke Door Inspections" **B.** All doors were checked **C.** All fire doors will be labeled in the "Fire-Smoke Doors: Annual Fire/Smoke Door Inspections" **D.** The Life Safety POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director	02/18/2023

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	shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, Section 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity.		If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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	This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Fire-Smoke Doors (Opening Protectives): Annual Fire/Smoke Door Inspections" documentation dated 07/29/22 with the Maintenance Director during record review from 9:30 a.m. to 12:10 p.m. on 01/18/23, annual inspection documentation of fire door assemblies in the facility within the most recent twelve month period did not include all fire doors in the facility. The annual inspection documentation dated 07/29/22 included cross corridor door sets in the 100 Hall through the 500 Hall and doors near dining rooms. The annual inspection documentation did not include hazardous areas in the facility which were constructed prior to 2016 and did not include all fire doors in the facility. Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:15 p.m. on 01/18/23, entry room doors to over 10 hazardous areas such as fuel fired heater rooms, laundries larger than 100 square feet, soiled linen and trash collection rooms and storage rooms larger than 100 square feet used for storing combustible material were noted in the facility. Each entry door to the rooms was a fire-rated door with a minimum 45-minute fire resistance rating label affixed to the door. In addition, the entry door to the oxygen storage and transfilling room in the service corridor was equipped with a 1-hour fire resistance rating label affixed to the hinge side of the door. Nine liquid oxygen containers and ten 'E' type oxygen cylinders were observed stored in the room. Based on interview at the time of record review and of the observations, the Maintenance			

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	Director agreed it could not be ensured all fire door locations in the facility were included in the most recent annual fire door inspection documentation. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)			