STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155570	A. BUILDING 01 B. WING	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF MCCORDSVILLE	7476 W LANE RD MCCORDSVILLE, IN 46055

(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
K 0000 Bldg. 01	A Post Survey Revisit to the Life Safety Code Recertification and State Licensure Survey conducted on 05/15/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/11/23 Facility Number: 000477 Provider Number: 155570 AIM Number: 100290860 At this PSR Life Safety Code survey, Majestic Care of McCordsville was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two-story facility with a partial basement was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and in resident Room 22. The facility has battery operated smoke detectors in 20 of 21 resident sleeping rooms. The facility has a capacity of 48 and had a census of 32 at the time of this PSR survey. All areas where residents have customary access were sprinklered. The facility has an unsprinklered, detached 2 story wood frame pole barn housing a sprinkler system water storage tank and fire pump; an unsprinklered, detached 2 car garage used for oxygen storage; and an	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Katlyn Collins	HFA	07/31/2023

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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	unsprinklered, 2 story wood barn used for housing a lawn mower and tractor and a snow blower. Quality Review completed on 07/17/23			
K 0161 SS=F Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section			

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	9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. Based on record review, observation, and interview; the facility failed to ensure the building construction type for the two-story portion of the facility was a permitted type as listed in Table 19.1.6.1. Table 19.1.6.1 prohibits a two story sprinklered building to be of Type V(000) construction. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director and Executive Director on 07/11/23 between 1:25 p.m. and 3:00 p.m., the two-story portion of this fully sprinklered building had exposed wood as the structural element for the exterior load bearing wall and an interior load bearing wall in the sprinkler riser room in the basement. In addition, the top portion of the stairwell wall in the attic had exposed wood with one half inch thick plaster covering the interior portion of the stairwell wall. Residents have customary access to the dining room and the therapy room on the first floor of the two-story portion of the facility. Based on interview at the time of record review the Executive Director stated this was part of the FSES however, the requirements of the FSES of abandoning the second floor area and adding additional smoke detection in the basement have not been completed. This finding was acknowledged by the	K 0161	**It is the responsibility of the facility to ensure that the building construction type for the two-story portion of the facility is permitted.** **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents affected. **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. An FSES evaluation was conducted to ensure the facility construction type is permitted. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** An FSES evaluation was conducted to ensure the facility receives a passing score and the construction type is permitted. To meet requirements, we have closed down the second floor. Storage, offices and medical	07/25/2023

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	Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. This deficiency was cited on 05/15/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		records have all been removed as 7-25-23. see attachments The smoke detectors were hard wired to our fire alarm system on 7-19-23. see attachments **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The ED will assure that the second floor is abandoned and remains out of use. We will continue to monitor and bring to QAPI monthly.	
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 interview and observation the facility failed to maintain the required headroom space in the basement area. LSC section 7.1.5.1 states that the Means of egress shall be designed and maintained to provide headroom in accordance with other sections of this Code, and such headroom shall be not less than 7 ft 6 in. (2285 mm), with projections from the ceiling not less than 6 ft 8 in. (2030 mm) with a tolerance of ?3?4 in. (?19 mm), above the finished floor, unless otherwise specified by any of the following: (1) In existing buildings, the ceiling height shall be not	K 0211	**It is the responsibility of the facility to maintain the required headroom space in the basement area.** **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents affected. **How other residents that have the potential to be affected by the same defective practice**	07/26/2023

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	less than 7 ft (2135 mm) from the floor, with projections from the ceiling not less than 6 ft 8 in. nominal above the floor. (2) Headroom in industrial equipment access areas as provided in 40.2.5.2 shall be permitted. This deficient practice could affect up to 5 staff in the facility. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director and Executive Director on 07/11/23 between 1:25 p.m. and 3:00 p.m., in (1) the Oil Furnace Room and (2) Basement Storage area the ceiling height was below the required minimum height. Based on interview at the time of record review the Executive Director stated this was part of the FSES however, the requirements of the FSES of abandoning the second floor area and adding additional smoke detection in the basement have not been completed. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. This deficiency was cited on 05/15/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		**will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. An FSES evaluation was conducted to ensure the facility construction type is permitted. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** An FSES evaluation was conducted to ensure the facility receives a passing score. To meet requirements, we have closed down the second floor. Storage, offices and medical records have all been removed as 7-25-23. see attachments The smoke detectors were hard wired to our fire alarm system on 7-19-23. see attachments **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The ED will assure that the second floor is abandoned and remains out of use. We will continue to monitor and bring to QAPI monthly.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not			

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	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 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			

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	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 all exit doors were provided with only one latching mechanism to release the door and open. 33.2.2.5.7 refers to 7.2.1.5.10 which states a latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions. 7.2.1.5.10.4 states the releasing mechanism shall open the door leaf with not more than one releasing operation. 7.2.1.5.10.1 states the releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches, above the finished floor. This deficient practice could affect 6 occupants in the therapy area. Findings include:	K 0222	**It is the responsibility of the facility to ensure all exit doors are provided with only one latching mechanism to release the door and open.** **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents affected. **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. The deadbolt lock was removed. Please see attachment	07/25/2023

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	Based on observations and interviews during a tour of the facility with the Maintenance Director and Executive Director on 07/11/23 between 1:25 p.m. and 3:00 p.m., the Exit door to the outside from the basement area were equipped with two latching devices, a regular locking door handle and a deadbolt latching mechanism and thus requiring two operations to exit the door and not one releasing operation. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. This deficiency was cited on 05/15/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The deadbolt lock was removed see attachment.** **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: t**he maintenance director and/or designee will tour bldg monthly for 6 months to assure all doors only have one latching mechanism to release the door and open. All negative findings will be immediately remedied. All findings will be brought to the monthly QA meeting\.	
K 0225 SS=E Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Based on observation and interview, the facility failed to ensure 1 of 1 stairway enclosure door was in accordance with 7.2. LSC Section 7.2.1.5.10 requires a latch or other fastening device on a door leaf to be provided with a releasing device that has an obvious method of operation and is readily operated under all lighting conditions. This deficient practice affects 15 including staff and visitors.	K 0225	It is the responsibility of the facility to ensure that stairway enclosure door is in ac **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by**	10/11/2023

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	Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director and Executive Director on 07/11/23 between 1:25 p.m. and 3:00 p.m., the latch on the second floor stairwell exit door was not functioning and appeared to have been removed so the door failed to latch. Additionally, there was now approximately a 4 inch hole in the door. The Executive Director was informed that this vertical opening door would need to have the proper fire rated door and hardware even with the FSES in force. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. This deficiency was cited on 05/15/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		**the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** A door has been ordered but a temporary waiver has been requested because of the timeline of delivery. Please see attached order form. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The maintenance director and/or designee will audit all doors monthly x6 months. All findings will be reported to the monthly QAPI meeting.	
K 0232 SS=F Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 1. Based on observation and interview, the facility	K 0232	**It is the responsibility of the**	07/26/2023

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	failed to maintain the required corridor width throughout the facility. LSC 19.2.3.4* states any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as a means of egress from patient sleeping rooms. This deficient practice could affect all residents, staff, and visitors. Findings: Based on observations and interviews during a tour of the facility with the Maintenance Director and Executive Director on 07/11/23 between 1:25 p.m. and 3:00 p.m., the ramp and adjacent stairs measured 35 inches (ramp) and 33 inches (steps) in width. The Maintenance Director measured the widths of both the ramp and steps. Additionally, the aforementioned ramp which is approximately 15-20 feet in length, did not appear to this surveyor to meet the overall slope requirement for existing facilities which is 1 inch of fall for every 6 inches of rise. Based on interview at the time of record review the Executive Director stated this was part of the FSES however, the requirements of the FSES of abandoning the second floor area and adding additional smoke detection in the basement have not been completed. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. This deficiency was cited on 05/15/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 2. Based on observation and interview, the facility failed to keep all resident room corridors free from		**facility to ensure that the building construction type for the two-story portion of the facility is permitted.** **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents affected. **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. An FSES evaluation was conducted to ensure we meet requirements. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** An FSES evaluation was conducted to ensure the facility receives a passing score and the construction type is permitted. To meet requirements, we have closed down the second floor. Storage, offices and medical records have all been removed as 7-25-23. see attachments The smoke detectors were hard wired to our fire alarm system in the basement on 7-19-23. see attachments. With these items completed we are in compliance with our FSES score. **How the corrective action will**	

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	obstructions, trip hazards and obstacles as they exit the resident rooms. LSC 19.2.3.5 states that the aisle, corridor, or ramp shall be arranged to avoid any obstructions to the convenient removal of nonambulatory persons carried on stretchers or on mattresses serving as stretchers. This deficient practice could affect all residents, staff, and visitors. Findings: Based on observations and interviews during a tour of the facility with the Maintenance Director and Executive Director on 07/11/23 between 1:25 p.m. and 3:00 p.m., The ramp in front of Resident Room 211 crossed in front of the resident's room and contained at least a 2 inch drop creating an unsafe condition for nonambulatory The Executive Directors office was now in this room. Based on interview at the time of record review the Executive Director stated this was part of the FSES however, the requirements of the FSES of abandoning the second-floor area and adding additional smoke detection in the basement have not been completed. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. This deficiency was cited on 05/15/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		**be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The ED will assure that the second floor is abandoned and remains out of use. We will continue to monitor and bring to QAPI monthly.	
K 0241 SS=E	NFPA 101 Number of Exits - Story and Compartment			

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MAJESTIC CARE OF MCCORDSVILLE	7476 W LANE RD MCCORDSVILLE, IN 46055

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Bldg. 01	Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 The facility failed to provide the required number of exits from the basement area. LSC 19.2.4.4* states that Not less than two exits shall be accessible from each smoke compartment, and egress shall be permitted through an adjacent compartment(s), provided that the two required egress paths are arranged so that both do not pass through the same adjacent smoke compartment. This deficient practice could affect up to 5 staff in the facility. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director and Executive Director on 07/11/23 between 1:25 p.m. and 3:00 p.m., in the basement only one means of egress was provided. There appeared to be only one way into and one way out of the basement area. Based on interview at the time of record review the Executive Director stated this was part of the FSES however, the requirements of the FSES of abandoning the second-floor area and adding additional smoke detection in the basement have not been completed. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference.	K 0241	**It is the responsibility of the facility to ensure that the building construction type for the two-story portion of the facility is permitted and the amount of exits from the basement area.** **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents affected. **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. An FSES evaluation was conducted to ensure the facility construction type is permitted. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** An FSES evaluation was conducted to ensure the facility receives a passing score and the	07/25/2023

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	155570	A. BUILDING 01 B. WING	07/11/2023

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	This deficiency was cited on 05/15/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		construction type is permitted. To meet requirements, we have closed down the second floor. Storage, offices and medical records have all been removed as 7-25-23. see attachments The smoke detectors in the basement were hard wired to our fire alarm system on 7-19-23. see attachments. With these corrections made we meet compliance for our FSES survey. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The ED will assure that the second floor is abandoned and remains out of use. We will continue to monitor and bring to QAPI monthly.	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on interview and observation, it was determined that the facility failed to provide exterior emergency lighting for all exits. LSC Section 7.9.1.1 requires emergency lighting facilities for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect all occupants in the facility including staff, visitors, and residents if the facility were required to evacuate in an emergency	K 0291	**It is the responsibility of the facility to ensure that the exterior emergency lighting for all exits are equipped to work during power failure. Exterior exit lighting will be hooked to generator.** **The corrective action taken for those residents found to be**	07/25/2023

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	and the generator was providing electricity at that time. This deficient practice could affect everyone in the facility. Findings include: Based on observations and interviews during records review and a tour of the facility with the Maintenance Director and Executive Director on 07/11/23 between 1:25 p.m. and 3:00 p.m. it was unknown if the exterior lights for the exit discharge for all of the facility exits were connected to the generator. The Maintenance Director and the Executive Director stated that they had been told by their contractor that the exit lights were connected to the generator, but no documentation was provided to verify the facilities exit lighting were connected to the generator and could illuminate in the event of a power outage. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. This deficiency was cited on 05/15/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		**affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. The exterior emergency lighting was hooked to generator in case of power failure on 7/24/23. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The exterior emergency lighting was hooked to generator in case of power failure on 7/24/23 by safecare. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The maintenance director and/or designee will audit the exterior lighting monthly x 6 months to assure lighting is confirmed if power fails. All negative findings will be immediately remedied. All findings will be brought to the monthly QA meeting\. Executive Director to monitor.	

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K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g., duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: Based on observations and interviews during records review and a tour of the facility with the Maintenance Director and Executive Director on 07/11/23 between 1:25 p.m. and 3:00 p.m., no documentation was provided regarding a visual	K 0345	It is the responsibility of the facility to ensure that the fire alarm system in fully maintained and serviced. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. Contracted company Koorsen completed the visual semiannual fire alarm system inspection on 7-12-23 please see attached **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Contracted company Koorsen	07/13/2023

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	semi-annual fire alarm system inspection. During the survey, the Maintenance Director reached out to the vendor for the missing documentation but was unable to locate any further documentation. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. This deficiency was cited on 05/15/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		completed the visual semiannual fire alarm system inspection on 7-12-23 please see attached. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The maintenance director and/or designee will enter all completed contracted work into tels. monthly/quarterly and annual fire protection documentation will be brought to the monthly QAPI meeting for review. ED to oversee.	
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 Based on record review and interview, the facility	K 0353	**How other residents that have**	07/13/2023

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	failed to maintain 1 of 1 sprinkler system in accordance with 19.3.5.3. NFPA 25, 2011 Edition, 14.2.1 states except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice could affect all occupants. Findings include: Based on observations and interviews during records review and a tour of the facility with the Maintenance Director and Executive Director on 07/11/23 between 1:25 p.m. and 3:00 p.m., the most recent inspection of internal piping was dated 02/12/18, more than 5 years ago. Based on interview at the time of record review, the Maintenance Director agreed the last internal inspection performed was more than 5 years. No other documentation was provided to show a more recent internal pipe inspection had been conducted. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. This deficiency was cited on 05/15/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		**the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. Contracted company Koorsen completed the internal 5year sprinkler inspection on 7-12-23 please see attached **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Contracted company Koorsen completed the internal 5 year sprinkler inspection system inspection on 7-12-23 please see attached. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The maintenance director and/or designee will enter all completed contracted work into tels. monthly/quarterly and annual fire protection documentation will be brought to the monthly QAPI meeting for review. ED to oversee.	

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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 unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485			

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	Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 3 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 15 staff and residents. Findings include: Based on observations and interviews during records review and a tour of the facility with the Maintenance Director and Executive Director on 07/11/23 between 1:25 p.m. and 3:00 p.m., the corridor door failed to close and latch positively into the door frame in the upstairs Storage Room. Additionally, the aforementioned door had louvers and was not smoke tight. Based on interview at the time of record review the Executive Director stated this was part of the FSES however, the requirements of the FSES of abandoning the second-floor area and adding additional smoke detection in the basement have not been completed. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. This deficiency was cited on 05/15/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)	K 0363	**It is the responsibility of the facility to ensure cooridors have no impediment to closing and latching into the door frame.** **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents affected. **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. An FSES evaluation was conducted to ensure the facility construction type is permitted. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** An FSES evaluation was conducted to ensure the facility receives a passing score. To meet requirements, we have closed down the second floor. Storage, offices and medical records have all been removed as 7-25-23. see attachments The smoke detectors were hard wired to our fire alarm system on 7-19-23. see attachments. With this completed	07/25/2023

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			we meet standards and pass FSES criteria. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The ED will assure that the second floor is abandoned and remains out of use. We will continue to monitor and bring to QAPI monthly.	