STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155217	A. BUILDING -- B. WING	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGBURG, THE	1712 LELAND DR HUNTINGBURG, IN 47542

(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: 07/27/23 Facility Number: 000122 Provider Number: 155217 AIM Number: 100290560 At this Emergency Preparedness survey, The Waters of Huntingburg was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 95 certified beds. At the time of the survey, the census was 45. Quality Review completed on 08/01/23	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: 07/27/23 Facility Number: 000122 Provider Number: 155217 AIM Number: 100290560 At this Life Safety Code survey, The Waters of Huntingburg was found not in compliance with	K 0000	The Waters of Huntingburg 1712 LeLand Dr. Huntingburg, In. 47542 Survey Date 7/27/2023	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lyn Strauser	HFA	08/11/2023

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 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 (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 95 and had a census of 45 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered, except two wood sheds and one metal shed outside the southwest exit used for facility storage. Quality Review completed on 08/01/23			
K 0300 SS=C Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to replace battery operated smoke alarms installed in 23 of 66 resident sleeping rooms in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published	K 0300	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this	08/11/2023

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	instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect all residents, staff and visitors. Findings include: Based on interview on 07/27/23 at 9:00 a.m. during the entrance conference with the Administrator and Maintenance Director, the Administrator said the facility was in the process of replacing all of the resident room battery operated smoke alarms in the facility. She further said all resident room smoke alarms had been replaced except for resident rooms on the Unit 2 and Legacy halls that were currently unoccupied. Based on observations on 07/27/23 between 9:00 a.m. and 12:30 p.m. while performing record review, the Maintenance Director brought in several resident room battery operated smoke alarms. All of the resident room battery operated smoke alarms from Unit 2 and Legacy hall had manufactured dates of February 28, 2008. Based on interview at the time of observation of the smoke alarms, the Maintenance Director confirmed the smoke alarms had manufactured dates of February 28, 2008 and agreed they were past due for replacement. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. K300– It is the intent of the facility to ensure to replace battery operated smoke alarms installed in resident sleeping rooms in accordance with NFPA 72 to meet set standards. 1) CORRECTIVE ACTIONS TAKEN: a) On 8/11/2023 the Maintenance Supervisor/designee replaced the smoke alarms in Unit 2 and Legacy hall that were past due for replacement and documented the information on the Battery Operated Smoke Detector Maintenance Log to meet set standards. The Administrator verified the work on 8/11/23_____ . 2) ALL OTHERS WITH POTENTIAL TO BE AFFECTED: a) All residents and all staff and visitors have the potential to be affected but none were. 3) MEASURES TO PREVENT REOCCURRENCE: a) On _____ 8/11/23 _____ the Administrator inserviced the Maintenance Supervisor/designee	

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			on the requirement that battery operated smoke alarms must be maintained per manufacture's guidelines and documentation retained at the facility to meet set standards. b) Maintenance Supervisor/designee will ensure the battery operated smoke alarms are maintained per manufactures guidelines and document the results on the Battery-Operated Smoke Detector Maintenance Log to be filed in the Life Safety Binder as a part of the facility's Preventive Maintenance Program. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c) The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4) MONITORING CORRECTIVE ACTION: a) The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by	

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			the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is _____8/11/23 _____.	
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 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			

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	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) 1. Based on observation and interview, the facility failed to ensure the corridor doors to 3 of over 20 hazardous area doors, such as storage room doors, were provided with self closing devices. This deficient practice could affect mostly staff in the Unit 2 and Legacy halls, currently unoccupied by residents. Findings include: Based on observations on 07/27/23 between 12:30 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. The Chapel is currently being used as a storage room for plastic totes, cardboard boxes, and Christmas items. The room was over 50 square feet in size. There were two doors remote from each other to the Chapel from the egress corridor that were not provided with self closing devices. The Maintenance Director said the Chapel was only being used as a temporary storage room until some items were disposed of and others were put back in their proper storage room. b. Rooms 312 and 318 were currently being used as storage rooms for plastic totes, cardboard boxes, and old furniture. Neither room door to the corridor was provided with a self closing device. This was confirmed with the Maintenance Director at the time of each observation. This finding was reviewed with the Administrator	K 0321	K321– It is the intent of the facility to ensure the corridor doors to hazardous area doors, such as storage room doors, are provided with self closing devices and to ensure hazardous area doors, such as laundry room, kitchen and storage room doors, are not prevented from closing with impediments to meet set standards. 1. CORRECTIVE ACTIONS TAKEN: a. On _____ 7/27/23_____ the Maintenance Supervisor/designee removed all combustible items from the chapel to meet set standards. The Administrator verified the work on _____ 7/27/23 _____ . b. On _____7/27/23____ the Maintenance Supervisor/designee removed all combustible items from Rooms 312 & 318 to meet set standards. The Administrator verified the work on _____7/27/23 _____ . c. On _____7/27/23_____ the Maintenance Supervisor/designee removed the door wedges from the two laundry room doors to meet set standards.	08/11/2023

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	and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 4 of over 20 hazardous area doors, such as laundry room, kitchen, and storage room doors, were not prevented from closing with impediments. This deficient practice could affect at least 20 residents, staff and visitors. Findings include: Based on observations on 07/27/23 between 12:30 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. Two laundry room doors were held wide open with door wedges. b. The Housekeeping/Laundry Supervisor office/storage room door was held wide open with a door wedge. c. The kitchen door was held wide open with a door wedge. Based on interview at the time of each observation, this was acknowledged by Maintenance Director. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		The Administrator verified the work on _____7/27/23_____ . d. On _____7/27/23_____ the Maintenance Supervisor/designee removed the door wedge from the housekeeping/laundry supervisor office/storage room to meet set standards. The Administrator verified the work on _____7/27/23_____ . e. On _____7/27/23_____ the Maintenance Supervisor/designee removed the door wedge from the kitchen door to meet set standards. The Administrator verified the work on _____ 7/27/23_____ . 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED: a. All residents and all staff and visitors have the potential to be affected but none were. On _____7/27/23 _____ the Maintenance Supervisor/designee inspected all hazardous area doors for self closing devices and doors are not prevented from closing with impediments and found no other negative findings. 3. MEASURES TO PREVENT REOCCURRENCE: a. On _____7/27/23 _____ the Administrator inserviced the Maintenance Supervisor/designee/all staff on the requirement that all hazardous area doors must be protected with a self-closing device and self closes and latches into the frame	

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			and doors are not prevented from closing with impediments to meet set standards. b. Maintenance Supervisor/designee will inspect all hazardous area doors throughout the facility monthly to ensure there is a self-closing device and the door self closes and latches into the frame and doors are not prevented from closing with impediments as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with	

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			subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is _____8/11/23 _____	
K 0355 SS=B Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 25 portable fire extinguishers observed was installed in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than five feet above the floor. This deficient practice could affect up to 5 residents in the smoking area. Findings include: Based on observation on 07/27/23 between 12:30 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, there was an ABC portable fire extinguisher mounted on the wall in the outside resident smoking area. The top of the fire extinguisher was measured at over six feet from the floor to the top of the extinguisher.	K 0355	K355– It is the intent of the facility to ensure portable fire extinguishers are installed in accordance with NFPA 10 to meet set standards. 1. CORRECTIVE ACTIONS TAKEN: a. On _____7/27/23 _____ the facilities Maintenance Supervisor/designee reinstalled the ABC portable fire extinguisher mounted on the wall in the outside resident smoking area so that the top of the fire extinguisher is not more than five feet above the floor to meet set standards. The Administrator verified the work on _____ 7/27/23 _____ . 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED:	08/11/2023

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	Based on interview, this was acknowledged by the Maintenance Director at the time of observation. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		a. All residents and all staff and visitors have the potential to be affected but none were. 3. MEASURES TO PREVENT REOCCURRENCE: a. On _____7/27/23_____ the Administrator inserviced the Maintenance Supervisor/designee that portable fire extinguishers must be installed in accordance with NFPA 10 and to not exceed five feet above the floor to meet set standards. b. Maintenance Supervisor/designee will ensure portable fire extinguishers are installed in accordance with NFPA 10 and to not exceed five feet above the floor as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the	

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			Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is _____ _8/11/23_____.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 11 sets of smoke barrier doors	K 0374	K374 – It is the intent of the facility to ensure sets of smoke	08/11/2023

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	had no impediment to closing. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 07/27/23 between 12:30 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, the set of smoke barrier doors near rooms 107 and 108 were impeded from closing by a large lift. The lift was parked partially in front of the set of smoke barrier doors. This was acknowledged by the Maintenance Director who did remove the lift at the time of observation. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		barrier doors have no impediment to closing to meet set standards. 1. CORRECTIVE ACTIONS TAKEN: a. On _____7/27/23_____ the Maintenance Supervisor/designee removed the lift that was parked in front of the set of smoke barrier doors near rooms 107 and 108 to meet set standards. The Administrator verified the repairs on _____ 7/27/23_____ . 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED: a. All residents and all staff and visitors have the potential to be affected but none were. On _____7/27/23_____ the Maintenance Supervisor/designee inspected all smoke barrier doors throughout the facility and found no other negative findings. 3. MEASURES TO PREVENT REOCCURRENCE: a. On _____7/27/23 _____ the Administrator inserviced the Maintenance Supervisor/all staff/designee on the requirement that smoke barrier doors must have no impediments to closing to meet set standards. b. Maintenance Supervisor/designee will inspect all smoke barrier doors throughout the facility monthly to ensure they have no impediments to closing as a part of the facility's Preventive Maintenance Program and document those inspection results	

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			as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is _____8/11/23_____.	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills			

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	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 ensure 12 of 12 fire drill reports included complete and accurate documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 07/27/23 between 9:00 a.m. and 12:30 p.m. with the Maintenance Director present, all 12 fire drill reports performed during the past 12 month period were not provided with complete and accurate documentation for the transmission of the alarm to the monitoring company. The reports did not include the name or operator number of the person at the monitoring company. Furthermore, the four fire drill reports provided for the third shift fire drills during the past 12 month period were listed as silent drills, however, the reports indicated the monitoring company received the transmission of the alarm at the time of the fire drill. Based on interview at the time of record	K 0712	K712 – It is the intent of the facility to ensure fire drill reports include complete and accurate documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months to meet set standards. 1. CORRECTIVE ACTIONS TAKEN: a. On _____7/27/23 _____ the Administrator inserviced the Maintenance Supervisor/designee on the requirement that 1. fire drill reports must be provided with complete and accurate documentation including the name or operator number of the person at the monitoring company receiving the call 2. On all silent fire drills, the Maintenance supervisor will activate the fire alarm system (during normal business hours) to verify proper working condition of all initiating devices including transmission of the alarm received by the monitoring company to meet set	08/11/2023

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	155217	A. BUILDING 01 B. WING	07/27/2023

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	review, the Maintenance Director acknowledged there was not complete and accurate information on all the fire drill reports to verify that transmission of the alarm was received by the monitoring company. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3-1.19(b)		standards. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED: a. All residents and all staff and visitors have the potential to be affected but none were. 3. MEASURES TO PREVENT REOCCURRENCE: a. Maintenance Supervisor/designee will ensure fire drill reports are provided with complete and accurate documentation including the name or operator number of the person at the monitoring company receiving the call and on all silent fire drills, the Maintenance supervisor will activate the fire alarm system (during normal business hours) to verify proper working condition of all initiating devices including transmission of the alarm received by the monitoring company as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. b. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE	

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			ACTION: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is _____8/11/23_____.	
K 0761 SS=B Bldg. 01	Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 1 of 1 oxygen room fire door assembly was completed in accordance with 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	K 0761	K712 – It is the intent of the facility to ensure fire drill reports include complete and accurate documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months to meet set standards. 1. CORRECTIVE ACTIONS TAKEN: a. On _____7/27/23 _____ the Administrator inserviced the	08/11/2023

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	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 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, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 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.		Maintenance Supervisor/designee on the requirement that 1. fire drill reports must be provided with complete and accurate documentation including the name or operator number of the person at the monitoring company receiving the call 2. On all silent fire drills, the Maintenance supervisor will activate the fire alarm system (during normal business hours) to verify proper working condition of all initiating devices including transmission of the alarm received by the monitoring company to meet set standards. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED: a. All residents and all staff and visitors have the potential to be affected but none were. 3. MEASURES TO PREVENT REOCCURRENCE: a. Maintenance Supervisor/designee will ensure fire drill reports are provided with complete and accurate documentation including the name or operator number of the person at the monitoring company receiving the call and on all silent fire drills, the Maintenance supervisor will activate the fire alarm system (during normal business hours) to verify proper working condition of all initiating devices including transmission of the alarm received by the monitoring company as a part of	

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	(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect over 20 residents, as well as staff, and visitors. Findings include: Based on record review on 07/27/23 between 9:00 a.m. and 12:30 p.m. with the Maintenance Director present, the facility was unable to provide documentation for an annual inspection of the oxygen transfilling room fire door assembly. Based on interview at the time of record review, the Maintenance Director said there was no documentation of an annual inspection of the oxygen transfilling room fire door assembly. Based on observations during a tour of the facility with the Maintenance Director between 12:30 p.m. and 3:15 p.m., there was one oxygen transfilling room fire door assembly noted in the facility. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. b. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is _____8/11/23_____.	

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K 0920 SS=D 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 power strips were not used as a substitute for fixed wiring in 1 of 66 resident rooms. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect two residents.	K 0920	K920– It is the intent of the facility to ensure power strips are not used as a substitute for fixed wiring in resident rooms to meet set standards. 1. CORRECTIVE ACTIONS TAKEN: a. On _____7/27/23 _____ the Maintenance Supervisor/designee removed the two power strips from room 125 to meet set standards. The	08/11/2023

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	Findings include: Based on observations on 07/27/23 between 12:30 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, Room 125 had two power strips being used, one at each bed. Neither power strip met the UL requirements for being used within a resident room. Both power strips were hanging from the beds. Both power strips had a variety of items plugged in, including medical equipment, as well as a refrigerator and cell phone chargers. This was acknowledged by the Maintenance Director at the time of observation, along with the Administrator, whom the Maintenance Director had called into the room. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		Administrator verified the removal of the cord on _____ 7/27/23 _____ . 2. ALL OTHERS WITH POTENTAL TO BE AFFECTED: a. All residents and all staff and visitors have the potential to be affected but none were. On _____7/27/23_____ the Maintenance Supervisor/designee inspected all rooms throughout the facility for power strips and found no other negative findings. 3. MEASURES TO PREVENT REOCCURRENCE: a. On _____7/27/23_____ the Administrator inserviced the Maintenance Supervisor/designee and all other staff on the requirement that power strips are not to be used as a substitute for fixed wiring to provide power equipment with a high current draw in the facility to meet set standards. b. Maintenance Supervisor/designee will inspect all rooms throughout the facility monthly and remove any non approved power strips found as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor	

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			adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is _____8/11/23_____.	