STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155159	A. BUILDING -- B. WING	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT CITY NURSING AND REHABILITATION	2940 N CLINTON ST FORT WAYNE, IN 46805

(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: 01/09/24 Facility Number: 000079 Provider Number: 155159 AIM Number: 100266160 At this Emergency Preparedness survey, Summit City Nursing and Rehabilitation was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 93 and had a census of 43 at the time of this survey. Quality Review completed on 01/11/24	E 0000		
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility]			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jae Gerardot	Executive Director	01/30/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155159	A. BUILDING -- B. WING	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT CITY NURSING AND REHABILITATION	2940 N CLINTON ST FORT WAYNE, IN 46805

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	must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient	E 0004	**E 004 SS=C – Develop EP plan, review and update annually** **What corrective action(s) will be accomplished for those**	01/26/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155159	A. BUILDING -- B. WING	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT CITY NURSING AND REHABILITATION	2940 N CLINTON ST FORT WAYNE, IN 46805

(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
	practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 01/09/24 at 10:41 a.m., the administrator's copy of the EEP was reviewed on 10/09/23 but the EPP binder from the two nurses' stations and maintenance office were not reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director confirmed 3 of 4 EPP binders were not reviewed and updated within the last year. This finding was reviewed with the Maintenance Director during the exit conference.		**residents found to have been affected by the deficient practice.***Maint Director to be in serviced on updating All EP binders yearly.* **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** *Staff and residents have the risk of not having updated EP information available in ALL binders in case of emergency.* **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Updated EP will be placed at nurse station and Maint Director will also retain a copy. This will be updated yearly during QAPI in January/and as needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed.***ED will ensure that maintenance director updates EP binder. Maint Director to audit weekly X2 for 1 month then monthly for 12 months after to ensure binder is in place and current.* **Date of Compliance1/26/2024**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155159	A. BUILDING -- B. WING	01/09/2024

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E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155159	A. BUILDING -- B. WING	01/09/2024

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SUMMIT CITY NURSING AND REHABILITATION	2940 N CLINTON ST FORT WAYNE, IN 46805

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	develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.			
	Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include:	E 0013	**E 013 SS=C – Develop of EP Policies and Procedures** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.***Maint Director*	01/26/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Based on records review with the Maintenance Director on 01/09/24 at 10:41 a.m., the administrator's copy of the EEP Policies and Procedures were reviewed on 10/09/23 but the EPP binder from the two nurses' stations and maintenance office were not reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director confirmed 3 of 4 EPP binders containing the Policies and Procedures were not reviewed and updated within the last year. This finding was reviewed with the Maintenance Director during the exit conference.		*to be in serviced on updating All EP binders policies and procedures yearly.* **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** *Staff and residents have the risk of not having updated EP policy and procedure information available in ALL binders in case of emergency.* **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Updated EP policies and procedures will be placed at nurse station and Maint Director will also retain a copy. This will be updated yearly during QAPI in January/and as needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed.***ED will ensure that maintenance director updates policy and procedures EP binder. Manit Director to audit weekly X2 for 1 month then monthly for 12 months after to ensure binder is in place and current.* **Date of Compliance1/26/2024**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 01/09/24 at 10:41 a.m., the administrator's copy of the EEP Communication Plan was reviewed on 10/09/23 but the EPP binder from the two nurses' stations and maintenance office were not reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director confirmed 3 of 4 EPP binders containing the Communication Plan were not reviewed and updated within the last year.	E 0029	**E 029 SS=C – Development of Communication Plan** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** *Maint Director to be in serviced on updating Communication Plan in All EP binders, yearly.* **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** *Staff and residents have the risk of not having updated EP*	01/26/2024

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	This finding was reviewed with the Maintenance Director during the exit conference.		*Communication Plan available in ALL binders in case of emergency.* **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** *Updated Communication Plan will be put in EP Binder will be placed at nurse station and Maint Director will also retain a copy. This will be updated yearly during QAPI in January/and as needed.* **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed.** *ED will ensure that maintenance director updates Communication Plans in EP binders. Maint Director to audit weekly X2 for 1 month then monthly for 12 months after to ensure binder is in place and current.* *Date of Compliance 1/26/2024*	
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d),			

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	485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least			

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	annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.			
	Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Training Program at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 01/09/24 at 10:41 a.m., the	E 0036	E 036 SS=C – EP Training and Testing **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Maint Director to be in serviced on updating with Training and Testing	01/26/2024

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	administrator's copy of the EEP Training Program was reviewed on 10/09/23 but the EPP binder from the two nurses' stations and maintenance office were not reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director confirmed 3 of 4 EPP binders containing the Training Program were not reviewed and updated within the last year. This finding was reviewed with the Maintenance Director during the exit conference.		in All EP binders. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** Staff and residents have the risk of not having updated EP Training and Testing in ALL binders in case of emergency. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Updated Training and Testing will be put in EP Binder will be placed at nurse station and Maint Director will also retain a copy. This will be updated yearly during QAPI in January/and as needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed.** ED will ensure that maintenance director updates Training and Testing in EP binders. Maint Director to audit weekly X2 for 1 month then monthly for 12 months after to ensure binder is in place and current. Date of Compliance 1/26/2024	

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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: 01/09/24 Facility Number: 000079 Provider Number: 155159 AIM Number: 100266160 At this Life Safety Code survey, Summit City Nursing and Rehabilitation 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 basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor, areas open to the corridor and battery-operated smoke detectors in the resident rooms. The facility has a vent unit on the second floor and is fully protected by Type I EES 350 kW diesel powered generator. The facility has a capacity of 93 and had a census of 43 at the time of this survey. All areas where the residents have customary access are sprinklered. The facility does have a shed providing facility services that was not sprinklered. Quality Review completed on 01/11/24	K 0000		

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SUMMIT CITY NURSING AND REHABILITATION	2940 N CLINTON ST FORT WAYNE, IN 46805

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K 0223 SS=E Bldg. 01	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure 1 of 2 laundry room corridor doors to a hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2. This deficient practice could affect staff in the basement. Findings include: Based on observation with the Maintenance Director on 01/09/24 at 12:10 p.m., the clean side laundry room corridor door was held open with a chair. Based on interview at the time of observation, the Maintenance Director agreed the door was held open with a device that did not release with the fire alarm and removed the chair. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)	K 0223	**K 0223 SS=E – Doors with Self Closing Devices** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** *Maint Director and Laundry staff to be in serviced on not propping doors open with a chair.* **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** *Staff and residents have the risk*	01/26/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155159	A. BUILDING 01 B. WING	01/09/2024

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			of doors not properly closing in case of emergency due to being propped open. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** All chairs will be relocated away from the doors to ensure they are not used as a prop. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed.** *Maint Director will remove all chairs away from the door that was propped open and to audit weekly X5 for 1 month then monthly for 12 months after to make sure no chairs are propping doors.* **Date of Compliance** **1/26/2024**	
K 0321 SS=E	NFPA 101 Hazardous Areas - Enclosure			

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Bldg. 01	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 d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of 12 unoccupied resident rooms on the 100-hall with large amounts of combustible storage and greater than 50 square feet was protected as a hazardous area. This deficient practice could affect 10 residents.	K 0321	**K 321 SS=E – Hazardous Areas- Enclosure** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.***Maint Director*	01/26/2024

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	Findings include: Based on observation with Maintenance Director on 01/09/24 at 11:36 a.m., room 132 was being used as storage, contained over 20 boxes of supplies, was greater than 50 square, therefore making the rooms hazardous areas. The room was not protected as a hazardous area because the corridor door to the room was not self-closing or automatic closing. Based on interview at the time of observation, the Maintenance Director agreed the room contained large amount of combustible storage, was larger than 50 square feet, and the corridor door to the room was not self-closing. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		*will add a self-closure to room 132.* **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** *Staff and residents have the risk of doors not properly closing in case of emergency due to the lack of self-closure on door of room 132.***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.**Room 132 will have self-closure added due to having supplies stored and being over 50quare feet. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed.***Maint Director add closure to room 132 door and audit weekly for 1 month and for x1 monthly for 12 months after to make sure closure remains intact.* **Date of Compliance1/26/2024**	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:			

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	155159	A. BUILDING 01 B. WING	01/09/2024

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	* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			
	#1) Based on observation and interview, the facility failed to maintain 1 of 1 kitchens in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011. NFPA 96, Section 12.1.2.4 states all deep-fat fryers shall be installed with at least a 16 inches space between the fryer and surface flames from adjacent cooking equipment. Section 12.1.2.5 states where a steel or tempered glass baffle plate is installed at a minimum 8 inches in height between the fryer and surface flames of the adjacent appliance, the requirement for a 16 inches space shall not apply. This deficient practice could affect staff in the kitchen. Findings include: Based on an observation with the Maintenance Director on 01/09/24 at 12:45 p.m., in the kitchen the deep fat fryer was located 6 inches from the gas burners on the commercial cooking stove and	K 0324	**K 324 SS=E – Cooking Facilities** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.***Maint Director will secure 2 baffles on the kitchen hood system. LA electrical will also insure shutoff will be added for the cook tops* **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** *Staff and residents are at risk due to the kitchen hood system not having secure baffles x 2 and not having a shut off on cook tops in case of an emergency.***What measures will**	01/26/2024

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	155159	A. BUILDING 01 B. WING	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	did not have a protective shield measuring at least eight inches in height between the two appliances. Based on interview at the time of observation, the Maintenance director agreed the fryer was less than 16 inches from an open flame. #2) Based on observation and interview, the facility failed to maintain 1 of 1 kitchens in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011. NFPA 96, Section 6.1.1 states listed grease filters, listed baffles, or other listed grease removal devices for use with commercial cooking equipment shall be provided. This deficient practice could affect staff in the kitchen. Findings include: Based on an observation with the Maintenance Director on 01/09/24 at 12:45 p.m., in the kitchen, the hood system was missing two baffles. Based on interview at the time of observation, the Maintenance Director found the baffles and tried to put them back in, but the baffles would not stay in the hood. The Maintenance Director stated the baffles will need to be repaid. #3.) Based on observation and interview, the facility failed to ensure staff had access to the shutoff switch for 2 of 3 cook tops in the therapy gym. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room.		**be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.**The kitchen hood system will have 2 baffles secured to it for proper function and safety, as well as a shutoff for the cook tops. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed.***Maint Director will add 2 baffles to the kitchen hood system and shut off for cook top and check weekly x2 for 1 month then x1 monthly for 12 months after to make sure baffles are secured to the kitchen hood system.* **Date of Compliance1/26/2024**	

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	(2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect five residents in the therapy gym and staff in the conference room. Findings include: Based on observation with the Maintenance Director on 01/09/24 at 11:14 a.m., there was a cooktop in the therapy gym and in conference room that was separated from the corridor, but the unattended cooktops were connected to power and had no available way to deactivate the cooktops from power. Based on interview at the time of observation, the Maintenance Director agreed both cooktops were not in use, still connected to power, and stated there was not a shutoff for the two cooktops. The findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems			

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	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 observation and interview, the facility failed to maintain the ceiling construction of 1 of 1 break rooms and 1 of 1 vent unit mechanical room. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice affects 10 residents on the vent unit. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 01/09/24 at 1:50 p.m., the following was observed: A.) In the break room suspended ceiling there was a ceiling tile missing exposing the ceiling about two feet above the suspended ceiling. B.) In the mechanical room on the vent unit the ladder access to the roof was exposed to the roof hatch about four feet above the suspended	K 0353	**K353 SS=E – Sprinkler System – Maintenance and Testing** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** *Maint Director will replace missing ceiling tile in breakroom and roof hatch will be unexposed to roof via latter access.* **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** *Staff and residents are at risk*	01/26/2024

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	ceiling. These conditions could delay the activation of the sprinklers installed on the suspended ceilings. Based on interview at the time of the observations, the Maintenance Director agreed there were missing ceiling tiles that exposed the ceiling above the drop ceiling. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		*due to missing ceiling tile in breakroom and roof hatch that exposed the roof via latter access.* **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** *Maint Director will replace missing ceiling tile in breakroom and roof hatch will be unexposed to roof via latter access.* **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed.** *Maint Director will replace missing ceiling tile in breakroom and roof hatch will be unexposed to roof via latter access. This will be audited for 1 month x1 weekly then x1 monthly for 12 months after to make sure baffles are secured to the kitchen hood system and cook top shutoffs are in place* **Date of Compliance** **1/26/2024**	

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K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview; the facility failed to ensure staff used 1 of 1 smoking areas and maintained the grounds by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect staff and 30	K 0741	**K741 SS=E – Smoking Regulations** **What corrective action(s) will be accomplished for those**	01/26/2024

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	155159	A. BUILDING 01 B. WING	01/09/2024

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	residents using the front entrance. Findings include: Based on observation with the Maintenance Director on 01/09/24 between 9:00 a.m. and 2:00 p.m., outside of the exit dock area, a staff member was observed smoking in a non-smoking area, also there were over 30 cigarette butts disposed on the ground around the dock and 30 cigarette butts in the vent pit by the front entrance. Based on interview at the time of observations, the Maintenance Director agree there were cigarette butts on the ground and the staff smoking area was in the gazebo at the edge of the parking lot and not at the docks. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		**residents found to have been affected by the deficient practice.** *Maint Director will Inservice all smokers to smoke in designated smoking area and clean up cig butts found around facility.* **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** *Staff and residents are at risk of an emergency due to staff not smoking in the approved area.* **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** *Maint Director will educate smokers to smoke in the facility smoking area "gazebo" for safety and pick up cig butts around the facility.* **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed.**	

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	155159	A. BUILDING 01 B. WING	01/09/2024

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			Maint Director will educate staff on smoking location and pick up cig butts found on facility property. This will be audited for X5 a week for month, then x2 monthly for 12 months to ensure staff smoke in approved areas and are not placing cigs on the ground. **1/26/2024**	