STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING -- B. WING	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW HEALTHCARE CENTER	333 W MISHAWAKA RD ELKHART, IN 46517

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/17/2021 Facility Number: 000523 Provider Number: 155496 AIM Number: 100266930 At this Emergency Preparedness survey, Valley View Healthcare Center, was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 94 certified beds. At the time of the survey, the census was 88. Quality Review completed 05/24/21	E 0000	**K000** Attached is the plan of correction for the Life Safety Code with Emergency Preparedness E 009Survey conducted at Valley View Health Center May 17, 2021. The facility is respectfully requesting desk review regarding this survey.	
E 0035 SS=C Bldg. --	483.475(c)(8), 483.73(c)(8) LTC and ICF/IID Sharing Plan with Patients §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC 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 annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain			

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

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	an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). This deficient practice could affect all occupants. Findings include: During record review with the Director of Nursing, and Maintenance Director on 05/17/2021 at 11:45 a.m. the facility was unable to provide documentation which ensured the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives. Based on interview at the time of record review, the Director of Nursing agreed that she was unable to locate a policy or documented method which ensures the emergency preparedness communication plan includes a method for sharing information with residents and their families or representatives. This deficient practice was reviewed with the	E 0035	**E 035** 1. The emergency preparedness plan for Valley View has been revised to include the process for communication and information sharing from the emergency plan that the facility has determined is appropriate with residents and their families or representatives. Documentation logs have been created to log all communication. 2. The process for communication and collaboration with residents and their families or representatives has been added to June's QAPI meeting. 3. In addition to reviewing the emergency preparedness plan annually with full IDT a quarterly meeting has been scheduled with ED and Maintenance Director to discuss reach out to residents though resident council and family/representative using our phone tree to discuss any changes or news. 4. The results of these quarterly emergency preparedness meetings will be	06/20/2021

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	Director of Nursing at the time of exit.		forwarded to the facility Safety Committee for follow up as needed. The safety committee will monitor for 6 months or longer if substantial compliance is not maintained. 5. Completion Date June 20, 2021	
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: 05/17/2021 Facility Number: 000523 Provider Number: 155496 AIM Number: 100266930 At this Life Safety Code survey, Valley View Healthcare Center 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 one story facility was determined to be of Type V (111) construction and was fully sprinklered. The 500, 600, and 700 Hall Units, which are in the southern portion of the facility, are decommissioned and do not have any residents living in them. The facility has a fire alarm system with smoke detection in the	K 0000	**K000** Attached is the plan of correction for the Life Safety Code with Emergency Preparedness E 009Survey conducted at Valley View Health Center May 17, 2021. The facility is respectfully requesting desk review regarding this survey.	

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	corridors, in areas open to the corridors, and 1 resident room. Battery operated smoke detectors are provided in 74 of 75 rooms resident rooms. The facility is fully protected by a 75 kW natural gas generator. The facility has a capacity of 94 beds dually certified for Medicare and Medicaid. At this survey the facility had a census of 88. All areas where residents have customary access were sprinklered. The facility has a detached garage providing storage of maintenance equipment and a shed containing storage of wheel chairs and walkers which were not sprinklered. Quality Review completed 05/24/21			
K 0211 SS=D 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 record review, observation and interview; the facility failed to ensure 1 of 1 Chemical Storage Room means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect staff only. Findings include: During a facility tour with the Director of	K 0211	**K211** 1. Means of Egress – ED has in-serviced Director of Housekeeping on requirement for all means of egress to maintain free of obstructions to full use in case of emergency. 2. All residents have the potential to be effected by the deficient practice. ED or Director of Maintenance or designee will	06/20/2021

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	Nursing and the Maintenance Director on 05/17/2021 at 1:05 p.m. the Chemical Storage Room in the Laundry Room was large enough for a person to enter and was equipped with a padlock on the non-egress side. Based on interview at the time of observation, the Maintenance Director agreed that a person could be locked in the Chemical Storage Room and unable to escape during an emergency. This deficient practice was reviewed with the Director of Nursing at the time of exit. 3.1-19(b)		conduct expected and unexpected inspections of the chemical storage room to ensure no obstructions are present. 3. ED will meet with Director(s) of Housekeeping and Maintenance to review audits that are tracking adherence to NFPA 10 quarterly to ensure continued adherence. Director(s) of Maintenance and Housekeeping have been in-serviced on requirement to keep means of egress free from obstruction to full use in case of emergency and their documentation has been added to June QAPI and Safety Committee meetings. 4. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 3 months or longer if substantial compliance is not maintained. 5. Completion Date June 20, 2021	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are			

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	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 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			

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	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 1) Based on observation and interview, the facility failed to ensure the delayed egress locking arrangements were installed in accordance with LSC Section 19.2.2.2.4 in 1 of 13 exits. Section 19.2.2.2.4 states that doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side, unless otherwise permitted. Section 19.2.2.2.4 (2) states that delayed-egress locks complying with 7.2.1.6.1 shall be permitted. LSC 7.2.1.6.1(3) states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This	K 0222	**K222** 1. Egress Doors– ED has in-serviced Director of Maintenance on requirement of LSC 19.2.2.2.4. A. The South Egress doors now have a 15 second delay installed. B. Also, the proper signage above the employee egress door has been installed indicating the doors can be opened in 15 seconds by pushing on the door. C. In addition the door that leads to the memory care unit has been affixed with the code to open the door. 2. All residents have the potential to be effected by the deficient practice. ED or Director of Maintenance or designee will conduct expected and unexpected inspections of all egress doors to ensure the 15 second delay is working correctly. 3. ED will meet with Director of Maintenance to review audits that	06/20/2021

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	deficient practice could affect 20 residents, staff, and visitors who may need to evacuate through the south exit of the facility. Findings include: During a tour of the facility with the Director of Nursing and the Maintenance Director on 05/17/2021 at 12:25 p.m., when the 15 second delayed South Exit egress doors were pushed, the irreversible process to release the lock was not initiated. Based on interview at the time of observation, the Director of Nursing and the Maintenance Director agreed that the door did not release when pushed for 15 seconds. This deficient practice was reviewed with the Director of Nursing at the time of exit. 3.1-19(b) 2) Based on observation and interview, the facility failed to ensure the means of egress through 1 of 13 delayed egress locks was readily accessible for all residents, staff, and visitors. LSC 7.2.1.6.1.(3) (4) states a readily visible, durable sign in letters not less than 1 in. (25mm) high and not less than 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect staff who need to evacuate through the Employee Exit. Findings include: During tour of the facility with the Director of Nursing and Maintenance Director on		are tracking adherence to requirements of LSC Section 19.2.2.2.4 quarterly to ensure continued adherence. Director of Maintenance has been in-serviced on requirement to install delayed egress locking arrangement are installed in accordance with LSC Section 19.2.2.2.4. and their documentation has been added to June QAPI and Safety Committee meetings. 4. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 3 months or longer if substantial compliance is not maintained. 5. Completion Date June 20, 2021	

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	05/17/2021 at 1:08 p.m., the single door Employee Exit was provided with delayed egress locks but lacked the proper signage indicating the doors can be opened in 15 seconds by pushing on the door. Based on interview at the time of observation, the Director of Nursing and Maintenance Director acknowledged the door was equipped with a delayed egress and lacked the proper signage. This deficient finding was reviewed with the Director of Nursing at the time of exit. 3.1-19(b) 3) Based on observation and interview, the facility failed to ensure the means of egress through 1 of 13 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 25 residents, staff and visitors if needing to exit the facility. Findings include: During a tour of the facility with the Director of Nursing, and Maintenance Director on 05/17/2021 at 1:15 p.m., the door that leads into the Memory Care Unit was marked as a facility exit, was magnetically locked and could be opened by entering a four digit code, but the code was not posted at the exit. Based on interview at the time of the observations, the Maintenance Director stated residents with a			

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	clinical diagnosis requiring specialized security measures are housed in the Memory Care Unit and acknowledged the aforementioned facility exits were marked as a facility exit and could be opened by entering a four digit code but the code was not posted. This deficient practice was reviewed with the Director of Nursing at the time of exit. 3.1-19(b)			
K 0223 SS=D 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 1 Kitchen Manager's Office door was only held open by a release device complying with LSC 7.2.1.8.2 that automatically closes such doors upon activation of the fire alarm system. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect all staff only.	K 0223	**K223** 1. Doors with Self Closing Devices– ED has in-serviced Director of Maintenance on requirement that doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed positon, unless held open by a	06/20/2021

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	Findings include: During a tour of the facility with the Director of Nursing, and the Maintenance Director on 05/17/2021 at 1:00 p.m. the door to the Kitchen Manager's Office was equipped with a self-closing device. When tested, the self-closing device failed to fully close the door so that it would latch into the frame. Based on interview at the time of observation, the Maintenance Director agreed that the door was equipped with a self-closing device, however, would not fully close the door so that it would latch. This deficient finding was reviewed with the Director of Nursing at the time of exit. 3.1-19(b)		release device. The self-closing device on the door to the dietary mangers office has been repaired and is in good working order. The door now closes and latches into the frame. 2. All residents have the potential to be effected by the deficient practice. ED or Director of Maintenance or designee will conduct expected and unexpected inspections of all doors that have a self-closing device on them to ensure they are working correctly. 3. ED will meet with Director of Maintenance to review audits that are tracking adherence to requirements of LSC Section 7.2.1.8.2 quarterly to ensure continued adherence. Director of Maintenance has been in-serviced on requirement and documentation has been added to June QAPI and Safety Committee meetings. 4. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 3 months or longer if substantial compliance is not maintained. 5. Completion Date June 20, 2021	
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			

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	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 record review and interview, the facility failed to ensure documentation for the preventative maintenance of 88 of 88 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of the Battery Operated Smoke Detector reports on 05/17/2021 at 12:45 p.m. with the Maintenance Director present, no documentation was available regarding purchase dates of the 10-Year Battery Smoke Alarms, or dates of replacement. Based on interview at the time of record review, the Maintenance Director stated that the resident rooms were equipped with 10-Year Battery Smoke Alarms, however agreed that he could not provide documentation of purchase dates, or when the smoke alarms were installed. He further stated that if the smoke alarm does not operate during its monthly test, it is replaced.	K 0300	**K300** 1. Protection – Other - ED has in-serviced Director of Maintenance on requirement that all smoke alarms in facility must have preventative maintenance documentation recorded. Also, the date of installation for all smoke alarms in resident rooms was July 2012. This has been recorded and is now being kept with the preventative maintenance and inspection logs of the smoke alarms. 2. All residents have the potential to be effected by the deficient practice. Director of Maintenance or designee will conduct scheduled inspections of all smoke alarms to ensure they are in good working order and that the documentation reflects that fact. 3. Director of Maintenance has been in-serviced on requirement and documentation has been added to June QAPI and Safety Committee meetings. 4. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 3 months or longer if substantial compliance is not maintained.	06/20/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This deficient practice was reviewed with the Director of Nursing at the time of exit. 3.1-19(b)		Completion Date June 20, 2021	
K 0321 SS=D 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 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)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 01 B. WING	05/17/2021

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	Based on observation and interview, the facility failed to ensure 1 of 1 hazardous areas, a Chemical Storage Closet, was protected in accordance with LSC Section 19.3.2.1. Section 19.3.2.1 states that any hazardous areas shall be safe-guarded by a fire barrier having a 1-hour fire-resistive rating or shall be provided with an automatic extinguishing system in accordance with Section 8.7.1. Where protected by sprinklers, the areas shall be separated from other spaces by smoke partitions in accordance with Section 8.4. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect staff in the kitchen only. Findings include: During a tour with the Director of Nursing and Maintenance Director on 05/17/2021, at 12:55 p.m. the Chemical Storage Closet, which contained hazardous chemical, was equipped with a door-closing device, however the door was propped open by boxes. Based on interview at the time of observation, the Maintenance Director agreed that the door would not automatically close because the door was propped open. It was noted that this was corrected prior to the exit. This deficient practice was reviewed with the Director of Nursing at the time of exit. 3.1-19(b)	K 0321	**K321** 1. Hazardous Areas-Enclosure– ED has in-serviced Director of Dietary hazardous chemical storage area door cannot be impeded by any object in order to keep it open. The self-locking mechanism on the door is in good working order. The boxes blocking the door from closing have been removed. 2. All residents have the potential to be effected by the deficient practice. ED or Director of Maintenance or designee will conduct expected and unexpected inspections of all doors to hazardous areas in the facility to ensure they are kept closed and not blocked. 3. ED will meet with Director of Maintenance to review audits that are tracking adherence to requirements of LSC Section 19.3-2.1 quarterly to ensure continued adherence. Director of Maintenance and Director of Dietary have been in-serviced on requirement and documentation has been added to June QAPI and Safety Committee meetings. 4. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 3 months or longer if substantial compliance is not maintained. 5. Completion Date June 20, 2021	06/20/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 01 B. WING	05/17/2021

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K 0353 SS=D 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 observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 kitchen in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff only. Findings include: During a facility tour with the Director of Nursing, and the Maintenance Director on 05/17/2021 at 1:02 p.m., a sprinkler in the kitchen had an escutcheon which did not properly sit against the ceiling. Based on interview at the time of observation, the Director of Nursing, and	K 0353	**K353** 1. Sprinkler System – Maintenance and Testing– The sprinkler head in the kitchen that was found to not be sitting correctly against the ceiling has been corrected. 2. All residents have the potential to be effected by the deficient practice. ED or Director of Maintenance or designee will conduct expected and unexpected inspections of all sprinkler heads to ensure they adhere to NFPA 13, 2010 Section 6.2.7.1 3. ED will meet with Director of Maintenance to review audits that are tracking adherence to requirements of NFPA 13, 2010	06/20/2021

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	155496	A. BUILDING 01 B. WING	05/17/2021

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	the Maintenance Director, agreed that the escutcheon was not properly placed against the ceiling. This deficient practice was reviewed with the Director of Nursing at the time of exit. 3.1-19(b)		Section 6.2.7.1 quarterly to ensure continued adherence. Director of Maintenance has been in-serviced on requirement and documentation has been added to June QAPI and Safety Committee meetings. 4. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 3 months or longer if substantial compliance is not maintained. 5. Completion Date June 20, 2021	
K 0355 SS=D 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 inspect 1 of 2 portable fire extinguishers in the kitchen. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting	K 0355	**K355** 1. Portable Fire Extinguishers – The portable fire extinguisher outside of the kitchen manager's office has been inspected. The face shield and any other PPE has been removed from atop the extinguisher. 2. All residents have the potential to be effected by the deficient practice. ED or Director of Maintenance or designee will conduct expected and unexpected inspections of all portable fire extinguishers to ensure nothing	06/20/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push-to-test pressure indicators. This deficient practice could affect staff only in the kitchen. Findings include: During a facility tour with the Director of Nursing, and the Maintenance Director on 05/17/2021 at 1:01 p.m. the fire extinguisher outside of the Kitchen Manager's Office had a face shield placed over the handle. Based on interview at the time of observation, the Maintenance Director agreed that the face shield obstructed the access of the extinguisher. This deficient practice was reviewed with the Director of Nursing at the time of exit. 3.1-19(b)		(including PPE) rests on top of them. 3. ED will meet with Director of Maintenance to review audits that are tracking adherence to requirements of NFPA 10 18.3.5.12, 19.3.5.12 to ensure continued adherence. Director of Maintenance has been in-serviced on requirement and documentation has been added to June QAPI and Safety Committee meetings. 4. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 3 months or longer if substantial compliance is not maintained. 5. Completion Date June 20, 2021	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to maintain 1 of 1 dining area in the Memory Care Unit, and 2 of 22 rooms in the decommissioned section, to be separated from the corridors by a partition capable of resisting	K 0361	**K361** 1. Corridors – Areas Open to Corridor – The door to room 703 (decommissioned) has been	06/20/2021

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	the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect staff in the decommissioned section and up to 24 residents in the Memory Care smoke compartment. Findings include: During a tour of the facility with the Director of Nursing and Maintenance Director on 05/17/2021 at 12:30 p.m. the corridor door to room 703 (decommissioned) was missing. Then, at 12:35 p.m. the corridor door to room 503 (decommissioned) was missing. At 1:25 p.m., the corridor door to the dining area was found to be removed. The area was open to the corridor. There was no electrically supervised automatic smoke detection system in the area. During interview at the time of each observation, The Administrator and Maintenance Director stated that the door to the dining had been removed due to damage, and a replacement door had not yet arrived. They also agreed that there was no electrically supervised automatic smoke detection system in the area, and stated that the area was not under 24-hour observation. This deficient practice was reviewed with the Director of Nursing at the time of exit.		ordered from supplier. The door to room 503 has been ordered from supplier. The corridor door to the dining room on 400 hall now has a smoke detector installed. Also, the door for the dining room has been ordered from supplier. 2. All residents have the potential to be effected by the deficient practice. ED or Director of Maintenance or designee have taken proper steps to ensure the doors for the above listed areas have been ordered and installed upon delivery. 3. ED will meet with Director of Maintenance to review progress on supplier delivering the doors. 4. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 3 months or longer if substantial compliance is not maintained. 5. Completion Date June 20, 2021	

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	155496	A. BUILDING 01 B. WING	05/17/2021

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	3.1-19(b)			
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.			

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	19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. 1) Based on observation and interview, the facility failed to ensure 3 of at least 100 room doors to the corridor were maintained in accordance with LSC Section 19.3.6.3. Section 19.3.6.3.5 states that corridor doors shall be provided with a means for keeping the door closed. Section 19.3.6.3.10 states that doors shall not be held open by devices other than those that release when the door is pushed or pulled. This deficient practice could affect staff in the 500 Hall, and 24 residents, staff, and visitors in the Memory Care Unit. Findings include: During a tour of the facility with the Director of Nursing, and the Maintenance Director, on 05/17/2021, from 12:00 p.m. to 1:30 p.m., the following were found: a) At 12:20 p.m. the 500 Storage Room did not latch when tested. b) At 1:20 p.m. the Memory Care Unit TV room failed to latch when tested. c) At 1:30 p.m. the door to Room 412 failed to latch when tested. Based on interview at the time of each observation, the Maintenance Director confirmed that the door did not latch when tested. This deficient finding was reviewed with the Director of Nursing at the time of exit. 3.1-19(b)	K 0363	**K363** 1. Corridors-Doors – A. The door to storage room on 500 hall has been ordered from supplier. The door to the TV room on 400 hall has been ordered from supplier. The door from room 412 has been ordered from supplier. B. Anything blocking the rolling door to the kitchen has been removed. 2. All residents have the potential to be effected by the deficient practice. ED or Director of Maintenance or designee have taken proper steps to ensure the doors for the above listed areas have been ordered and installed upon delivery. ED or Director of Maintenance or designee will conduct expected and unexpected inspections of the rolling door to the kitchen to ensure it remains unobstructed. 3. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 3 months or longer if substantial compliance is not maintained. 4. Completion Date June 20, 2021	06/20/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	2) Based on observation and interview, the facility failed to ensure 1 of 1 Kitchen Rolling Door, which opened to the corridor, was provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke in accordance with LSC 19.3.6.3. This deficient practice could affect staff and up to 5 residents in the immediate area. Findings include: During a tour of the facility with the Director of Nursing and Maintenance Director on 05/17/2021, at 1:03 p.m. the rolling door to the kitchen, had a coffee cup in the way of the closing track. Based on interview at the time of observation, the Maintenance Director agreed that the door would not close with the cup in the way. It was noted that this was corrected at the time of observation. This deficient practice was reviewed with the Director of Nursing at the time of exit. 3.1-19(b)			
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved			

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	155496	A. BUILDING 01 B. WING	05/17/2021

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	sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure 1 of 7 smoke barrier walls was maintained in accordance with LSC Section 19.3.7.5. Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. Section 8.5.2 states that smoke barriers shall be continuous from outside wall to outside wall and continuous through all concealed spaces. This deficient practice could affect staff and at least 10 residents. Findings include: During a tour of the facility with the Maintenance Director on 05/17/2021 at 1:55 p.m. the smoke barrier by the Rehab Manager was found to have a 1/2 inch unsealed penetration around piping. Based on interview at the time of observation, the Maintenance Director agreed that there was a 1/2 inch unsealed penetration. This deficient finding was reviewed with the Director of Nursing at the time of exit. 3.1-19(b)	K 0372	**K372** 1. Subdivision of Building Spaces – Smoke Barriers – The smoke barrier by the Rehab Manager penetration has been sealed. 2. All residents have the potential to be effected by the deficient practice. ED or Director of Maintenance or designee have taken proper steps, including facility wide tour to ensure no other areas are in need of sealing. 3. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 3 months or longer if substantial compliance is not maintained. 4. Completion Date June 20, 2021	06/20/2021
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in			

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	service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to protect 1 of 1 electrical splices in accordance with NFPA 70, the National Electrical Code, Article 300.15. Article 300.15 states that a box shall be installed at each outlet and switch point for concealed knob-and-tube wiring. Fittings and connectors shall be used only with the specific wiring methods for which they are designed and listed. Where the wiring method is conduit, tubing, Type AC cable, Type MC cable, Type MI cable, nonmetallic-sheathed cable, or other cables, a box or conduit body shall be installed at each conductor splice point, outlet point, switch point, junction point, termination point, or pull point, unless otherwise permitted in 300.15(A) through (L). This deficient practice could affect staff only in the laundry room. Findings include: During a tour of the facility with the Director of Nursing, and the Maintenance Director on 05/17/2021 at 1:08 p.m. an electrical splice for a light was found unprotected as the light had been removed. Based on interview at the time of observation, the Maintenance Director agreed the splice box was unprotected and that conductors were visible. This deficient finding was reviewed with the Director of Nursing at the time of exit. 3.1-19(b)	K 0511	**K511** 1. Utilities – Gas and Electric – The splice box has been protected and no conductors are visible. 2. All residents have the potential to be effected by the deficient practice. ED or Director of Maintenance or designee have taken proper steps, including facility wide tour to ensure no other areas have exposed conductors. 3. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 3 months or longer if substantial compliance is not maintained. 4. Completion Date June 20, 2021	06/20/2021
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills			

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	155496	A. BUILDING 01 B. WING	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 1) Based on record review and interview, the facility failed to conduct and document fire drills in accordance with LSC Section 19.7. Section 19.7.1.2 states that all employees shall be periodically instructed and kept informed with respect to their duties under the fire response plan. Section 19.7.2.3.1 states that all health care occupancy personnel shall be instructed in the use of and response to fire alarms. This deficient practice could affect facility occupants. Findings include: During record review with the Director of Nursing, and the Maintenance Director on 05/17/2021 at 10:40 a.m., the facility provided documentation of fire drills, however it was incomplete. The documentation for "Conduct Fire Drill for 1st Shift dated 04/28/2021, did not include the signatures of all staff who participated in the fire drills. Based on interview at the time of record review, the Director of Nursing stated that daytime personnel would be approximately 25. The fire drill only had the signatures of 11 of the 25. Additionally, the Maintenance Director agreed that all staff were not included in the signatures, and further, that documentation could not be provided which	K 0712	**K712** 1. Fire Drills – A. All employee acknowledgements of participation in the fire drill from first shift have been corrected and claimed. This was done using the employee roster and schedule for the date the drill was performed. B. A full in-service education with real time fire drill was performed on all three shifts with signatures of acknowledgement. 2. All residents have the potential to be effected by the deficient practice. ED or Director of Maintenance or designee have taken proper steps to ensure that documentation is available showing the proper documentation and performance of fire drills is conducted on all shifts. 3. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 3 months or longer if substantial compliance is not maintained.	06/20/2021

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	155496	A. BUILDING 01 B. WING	05/17/2021

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	ensured that all occupancy personnel had been instructed in the response to fire alarms. This deficient practice was reviewed with the Director of Nursing at the time of exit. 3.1-19(b) 2) Based on record review and interview, the facility failed to conduct and document fire drills in accordance with LSC Section 19.7. Section 19.7.1.7 states that when drills are conducted 9:00 p.m. and 6:00 a.m., a coded announcement shall be permitted to be used instead of the audible alarms. Section 19.7.1.4 states that fire drills in health care occupancies shall include the transmission of a fire alarm signal. This deficient practice could affect all building occupants. Findings include: During record review with the Director of Nursing, and the Maintenance Director on 05/17/2021 at 12:43 p.m., documentation indicated that a pull-station was used to initiate the overnight alarm test. Additionally, the documentation indicated that the off-site monitoring station response was N/A. Based on interview at the time of record review, the Maintenance Director stated that for overnight drills, he does not pull the pull station, it is only a verbal announcement for the drill. Additionally, he stated that he does not test the transmission of the fire alarm the next day. This deficient finding was reviewed with the Director of Nursing at the time of exit. 3.1-19(b)		4. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 3 months or longer if substantial compliance is not maintained. 5. Completion Date June 20, 2021	

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	3) Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the second shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drills" documentation with the Maintenance Director during record review from 9:30 a.m. to 11:45 a.m. on 05/17/2021, third shift (10:00 p.m. to 6:00 a.m.) fire drills conducted on 06/10/2021, 09/16/2021, 12/28/2021, and 03/31/2021 were conducted at, respectively, 10:30 p.m., 10:20 p.m., 10:40 p.m., and 10/21 p.m. Based on interview at the time of record review, the Maintenance Director agreed the aforementioned second shift fire drills were not conducted at unexpected times under varying conditions. 3.1-19(b)			
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.			

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	(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 maintain ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design in 1 of 1 outdoor areas where smoking is permitted. This deficient practice could affect staff, and up to 10 residents who smoke in the designated smoking area of the facility. Findings include: During a tour of the facility with the Director of Nursing and the Maintenance Director on 05/17/2021 at 12:15 a.m., over twenty cigarette butts were strewn on the ground outside the facility near the smoking area. Ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design were provided where smoking was permitted, however the facility did not ensure that residents who	K 0741	**K741** 1. Smoking Regulations – All cigarette butts have been collected from the ground near smoking area. Residents and staff who smoke have been educated on the use of ashtrays. 2. All residents have the potential to be effected by the deficient practice. ED or Director of Maintenance or designee will conduct expected and unexpected inspections of all smoking areas to ensure no smoke butts are present and that smokers are using ashtrays. 3. ED will meet with Director of Maintenance to review audits that are tracking adherence to requirements of 18.7.4, 19.7.4 to ensure continued adherence. Director of Maintenance has been	06/20/2021

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	smoked, or staff utilized the ashtrays. Based on interview at the time of observation, the Maintenance Director acknowledged ashtrays and metal containers were provided at the aforementioned location where staff and resident smoking was taking place. This deficient practice was reviewed with the Director of Nursing at the time of exit. 3.1-19(b)		in-serviced on requirement and documentation has been added to June QAPI and Safety Committee meetings. 4. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 3 months or longer if substantial compliance is not maintained. 5. Completion Date June 20, 2021	
K 0761 SS=E Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of at least 1 of 1 fire door assemblies were 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 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	K 0761	**K761** 1. Maintenance, Inspection & Testing- Doors –The door to the Oxygen room has been inspected and documentation is available. 2. All residents have the potential to be effected by the deficient practice. ED or Director of Maintenance or designee have taken proper steps to ensure that documentation is available showing the Oxygen storage room door inspection. 3. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 3 months or longer if substantial compliance is not maintained. 4. The results of these audits will be forwarded to the facility	06/20/2021

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	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. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect staff and up to 5 residents in the vicinity of the oxygen transfil room. Findings include: During record review with the Director of		Safety Committee for follow up as needed. The Safety Committee will monitor for 3 months or longer if substantial compliance is not maintained. 5. Completion Date June 20, 2021	

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	Nursing, and the Maintenance Director on 05/17/2021 at 11:04 a.m., the facility was unable to provide documentation of a fire door inspections for the oxygen transfill room. During a subsequent facility tour on the same day, it was determined that the oxygen transfill room had a fire-rated assembly and door. Based on interview at the time of record review, the Maintenance Director agreed that there was not an inspection for the oxygen transfill room, and at the time of observation, agreed that the room had a fire-rated assembly. This deficient finding was reviewed with the Director of Nursing at the time of exit. 3.1-19(b)			