STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155226	A. BUILDING -- B. WING	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(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: 06/26/24 Facility Number: 000131 Provider Number: 155226 AIM Number: 100274910 At this Emergency Preparedness survey, North Capitol Nursing & Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 123 certified beds. At the time of the survey, the census was 67. Quality Review conducted on 07/02/24	E 0000	To whom it may concern for, this provider requests a desk review in lieu of an in person PSR for event 4yph21. Please let me know if you any questions or if additional information is needed to assist in a desk review if granted. Thank you	
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: 06/26/24 Facility Number: 000131 Provider Number: 155226 AIM Number: 100274910 At this Life Safety Code survey, North Capitol	K 0000	To whom it may concern for, this provider requests a desk review in lieu of an in person PSR for event 4yph21. Please let me know if you any questions or if additional information is needed to assist in a desk review if granted. Thank you	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Roland Todd Mann	Executive Director	07/18/2024

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	Nursing and Rehabilitation 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. This four story facility was determined to be of Type II (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a total of 15 vent unit beds. Vent unit beds are located on the third floor in Rooms 319 through 326. The facility has a capacity of 123 and had a census of 67 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which was not sprinklered. Quality Review conducted on 07/02/24			
K 0161 SS=F Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and			

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	sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. Based on observation and interview, the facility failed to ensure the building construction type was a permitted type as listed in Table 19.1.6.1. Table 19.1.6.1 requires a sprinklered building, four or more stories in height, to be Type II (222), Type I (332) or Type I (442). This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m.	K 0161	K 161 **What corrective actions will be accomplished for those residents found to have been affected by this deficient practice?1. On 7/18/2024 a new FSES was completed using NFPA 101A, Guide on Alternative Approaches to Life Safety, 2001 Edition, post correction of items other than**	07/23/2024

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	to 4:15 p.m. on 06/26/24, this four story sprinklered building was constructed of unprotected steel and was determined to be Type II (000) construction. The interior load bearing wall above the suspended ceiling above the north stairwell door by Room 203, Room 302 and Room 402 was unprotected. This results in a construction type classification of Type II (000). Based on interview at the time of the observations, the Maintenance Director stated there was no change in the construction type since the most recent Life Safety Code survey and agreed interior load bearing walls consisted of unprotected steel. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		**noted on K161. 2. How will you identify other residents that have the potential to be affected by this deficient practice?All residents and visitors have the potential to be affected by this deficient practice. 3. What measures will be put in place or what systemic changes will be made to ensure that this deficient practice does not recur? The facility completed a FSES worksheet on 7/18/2024 which resulted in all items in Worksheet 4.7.9 checked as "Yes" and all items in Worksheet 4.7.10 being identified as "Met". The 4/28/2023 FSES demonstrates the level of fire safety is equivalent to that prescribed by NFPA 101, Life Safety Code for Healthcare Occupancies. 4. Executive Director will ensure a FSES worksheet is completed annually.**	
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			
	Based on observation and interview, the facility failed to ensure the means of egress through 3 of 12 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 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 4:15 p.m. on 06/26/24, the door set to the vestibule for the Capitol Street entrance on the first floor, the first floor dining room exit to the Capitol Street courtyard, and the corridor door to the stairwell on the second floor by Room 203 were each marked as a facility exit with an exit sign. The Capitol Street courtyard had a courtyard gate which was locked but could be opened by entering a code to release the gate to open. Each of the exit doors could be opened by	K 0222	**What corrective actions will be accomplished for those residents found to have been affected by this deficient practice?** All doors identified during the tour missing and entry/exit code have been corrected with the appropriate codes posted. **2. How will you identify other residents that have the potential to be affected by this deficient practice** All visitors and resident have the potential to be affected by this deficiency. All entry/exit door have been audited by maintenance department and any missing the appropriate codes have been corrected **3. What measures will be put in place or what systemic changes will be made to ensure that this deficient practice does not recur?**	07/23/2024

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	entering a code into a keypad to release the door set to open but the code to release the exit doors to open was not posted at the exit doors. Based on interview at the time of the observations, the Maintenance Director stated residents who need to be in a secure wing are housed on the third floor and agreed the code to release the exit doors to open was not posted at the exit doors. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		. The maintenance department in-serviced on ensuring door codes are posted at all times. The maintenance director or designee will audit weekly to ensure no doors are missing the appropriate entry/exit codes . Audits to ensure door codes are posted will be conducted each week. **4. 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?** A egress QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5			

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	Based on record review, observation, and interview; the facility failed to meet the clear width requirement for 1 of 2 third floor corridors or met an exception per 19.2.3.4(4). LSC Section 19.2.3.4(4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 inches. (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect over 10 residents, staff and visitors if needing to exit the third floor of the facility. Findings include: Based on review of the "Fire/Explosion Emergency Action Plan" section of the "Emergency Preparedness Program" documentation dated 01/24/24 with the Administrator and the Maintenance Director during record review from 9:30 a.m. to 12:20 p.m. on 06/26/24, the health care occupancy fire safety plan addressed the relocation of wheeled equipment during a fire or similar emergency. Page 45 of the aforementioned documentation stated "Wheeled equipment in the corridor should be located out of the path of egress: shower room or similar area". Based on observations with the Maintenance Director during a tour of the facility	K 0232	**What corrective actions will be accomplished for those residents found to have been affected by this deficient practice?** All corridors identified as being obstructed have been corrected. The three Hoyer lifts stored in the corridor outside the DNS have been removed. **2. How will you identify other residents that have the potential to be affected by this deficient practice** All visitors and residents on the third floor have the potential to be affected by this deficiency. All corridors/aisles have been audited to ensure they are not obstructed and meet the clearance requirements. **3. What measures will be put in place or what systemic changes will be made to ensure that this deficient practice does not recur?** Staff to be in-serviced on ensuring all aisles/corridors are free from obstruction at all times. The ED or designee will audit weekly to ensure corridors/aisles are not obstructed. **4. 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?** A corridor QAPI Tool will be	07/23/2024

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	from 1:00 p.m. to 4:15 p.m. on 06/26/24, three Hoyer lifts were stored in the corridor outside the Director of Nursing Services on the third floor near the stairwell door which was marked as a facility exit with an exit sign. The storage of the wheeled equipment in the corridor restricted the width in the path of egress in the eight foot wide corridor to 45 inches. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned wheeled equipment reduced the clear unobstructed corridor width of the corridor to less than 60 inches. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to maintain the fire alarm system to ensure that it had accurate time and date information in accordance with the requirements of NFPA 101, 2012 edition, Sections 19.3.4 and 9.6 and NFPA 72, 2010 edition, Sections 14.1 and 14.1.1. This deficient practice could affect all residents, staff	K 0345	**What corrective actions will be accomplished for those residents found to have been affected by this deficient practice?** Fire panels that were identified to show inaccurate times have been	07/23/2024

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	and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 4:15 p.m. on 06/26/24, the remote fire alarm control panel at the second floor nurse's station read the time of day as 15:07 at 2:27 p.m. In addition, the main fire alarm system control panel located in the main electrical room on the first floor read the time of day as 16:27 at 3:46 p.m. Based on interview at the time of the observations, the Maintenance Director agreed the fire alarm system control panels for the facility displayed the incorrect time of day. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		reset and now display the correct times **2. How will you identify other residents that have the potential to be affected by this deficient practice** All visitors and resident have the potential to be affected by this deficiency. All fire panels have been audited and all times are now showing correctly by the Maintenance Director. **3. What measures will be put in place or what systemic changes will be made to ensure that this deficient practice does not recur?** All fire panels have been audited and all times are now showing correctly. The maintenance department in-serviced on ensuring fire alarm panels are displaying the correct time. The maintenance director or designee will audit weekly to ensure fire panel time displays are checked and are accurate~~. Audits will be conducted each week x 4, then monthly x4, then as needed if no trends are identified.~~ **4. 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?** A Fire alarm QAPI Tool will be utilized weekly x 4 weeks,	

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			monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to ensure 1 of 6 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be	K 0353	**What corrective actions will be accomplished for those residents found to have been affected by this deficient practice?** The sprinkler gauge identified during the tour has been replaced and appropriate documentation is	07/23/2024

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	replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 4:15 p.m. on 06/26/24, the manufacture date of 2018 was listed on the face of the antifreeze loop sprinkler system gauge in the third floor Housekeeping Cottage room. A sticker was affixed to the gauge stating the "Date Installed" was 03/01/18. The sticker was left blank in response to "Test or Replace". No recalibration date information was affixed to the sprinkler system gauge. Based on interview at the time of the observations, the Maintenance Director agreed the antifreeze sprinkler system gauge was more than five years old and agreed documentation of sprinkler system gauge replacement or recalibration was not available for review. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler heads loaded with a foreign material were replaced in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not		now available. The sprinkler head in the laundry room has been cleaned **2. How will you identify other residents that have the potential to be affected by this deficient practice** All visitors and residents have the potential to be affected by this defi ciency. **All sprinkler heads were inspected by Maintenance to ensure sprinkler heads were clean by the Maintenance Director** **3. What measures will be put in place or what systemic changes will be made to ensure that this deficient practice does not recur?** The maintenance department to be in-serviced on ensuring sprinkler head gauges are tested/replaced and all sprinkler heads are free of debris. The maintenance director will inspect all sprinkler heads to ensure they are clean. The maintenance director or designee will audit weekly to ensure sprinkler gauges and sprinkler heads are in compliance. **4. 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?** A Sprinkler system qapi Tool will	

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	show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect over 2 staff and visitors in the Laundry. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 4:15 p.m. on 06/26/24, the sprinkler head installed in the Laundry behind the dryers was loaded with lint. Based on interview at the time of the observations, the Maintenance Director agreed the automatic sprinkler head was loaded with a foreign material. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
K 0361 SS=E	NFPA 101 Corridors - Areas Open to Corridor			

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Bldg. 01	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 ensure 1 of 1 therapy room on the fourth floor was separated from the corridor by a partition capable of resisting 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 over 5 residents, staff and visitors in the Therapy Room on the fourth floor. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 4:15 p.m. on 06/26/24, the annular space surrounding the door handle for the corridor door to the Therapy Room on the fourth floor would not resist the passage of smoke. The corridor was observed through the annular space when the door was in the fully closed and latched position. Based on interview at the time of the observations, the Maintenance Director agreed the corridor door to the Therapy Room would not	K 0361	**What corrective actions will be accomplished for those residents found to have been affected by this deficient practice?** The annular space surrounding the door handle in the therapy room has been corrected. No other issues identified. **2. How will you identify other residents that have the potential to be affected by this deficient practice** All visitors and residents in the therapy room have the potential to be affected by this deficient practice. Maintenance director will audit all annular space surrounding the door handles **3. What measures will be put in place or what systemic changes will be made to ensure that this deficient practice does not recur?** The maintenance department to be in-serviced on ensuring corridors are separated from rooms by a smoke resistant partition. The maintenance director or designee will audit weekly to ensure compliance in corridors and rooms for annual	07/23/2024

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	resist the passage of smoke when the door was in the fully closed and latched position. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		space. **4. 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?** A Corridor qapi Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
K 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			

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	covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of over 40 corridor doors to resident sleeping rooms had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of resident sleeping Room 212. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 4:15 p.m. on 06/26/24, the latching mechanism on the corridor door to resident sleeping Room 212 failed to protrude into the latching plate on	K 0363	**What corrective actions will be accomplished for those residents found to have been affected by this deficient practice?** The door near room 212 was corrected and now latches to resist the passage of smoke. The hanger was removed. No other issues issues noted. **2. How will you identify other residents that have the potential to be affected by this deficient practice** This deficient practice could affect over 20 residents, staff and visitors	07/23/2024

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	the door frame which prevented the corridor door from fully closing and latching into the door frame when tested to close multiple times. A hanger for isolation supply storage on the door was placed over the top of the door which prevented the door from fully closing. The door closed and latched into the door frame when the hanger was removed. Based on interview at the time of the observations, the Maintenance Director agreed the corridor door to resident sleeping Room 212 had an impediment to closing and latching into the door frame and would not resist the passage of smoke. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		in the vicinity of resident sleeping Room 212. All doors were checked for proper latching by the maintenance director. **3. What measures will be put in place or what systemic changes will be made to ensure that this deficient practice does not recur?** The maintenance department to be in-serviced on ensuring all doors latch properly to prevent the passage of smoke. All staff were inserviced on ensure exit door latch properly and there are no impediments to ensure closing of the door by maintenance director/designee. The maintenance director or designee will audit weekly to ensure doors opening to a corridor are in compliance with code. **4. 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?** A Corrirdor qapi Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 8 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect over 20 residents, staff and visitors on the first floor. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 4:15 p.m. on 06/26/24, the east door in the cross	K 0374	**What corrective actions will be accomplished for those residents found to have been affected by this deficient practice?** The east doors on the first floor have been corrected and now fully self close. No other issues identified. **2. How will you identify other residents that have the potential to be affected by this deficient practice** This deficient practice could affect all staff and visitors on the first floor. All doors were checked by the maintenance director to ensure	07/23/2024

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	corridor door set on the first floor by the reception desk failed to fully self close when tested to close multiple times. The meeting edge of the east door kept hitting the meeting edge of the west door which prevented the east door from fully closing. Based on interview at the time of the observations, the Maintenance Director agreed the east door in the corridor door set did not fully close when tested to close multiple times. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		doors fully self close. **3. What measures will be put in place or what systemic changes will be made to ensure that this deficient practice does not recur?** The maintenance department to be in-serviced on ensuring all doors in smoke barriers fully close properly to prevent the passage of smoke. The maintenance director or designee will audit weekly to ensure all doors in smoke barriers are in compliance. **4. 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?** A smoke barrier qapi Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
K 0914 SS=D Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general			

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	anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)			
	Based on record review, observation, and interview; the facility failed to ensure nonhospital-grade electrical receptacles that failed annual testing in 1 of over 40 resident rooms were replaced with hospital-grade receptacles. NFPA 70, The National Electrical Code, 2011 Edition, at Article 517.18(B) states each patient bed location shall be provided with a minimum of four receptacles. They shall be permitted to be of the single, duplex, or quadruplex type, or any combination of the three. All receptacles, whether four or more, shall be listed "hospital grade" and so identified. It is not intended that there be a total, immediate replacement of existing non-hospital grade receptacles. It is intended, however, that non-hospital grade receptacles be replaced with hospital grade receptacles upon modification of use, renovation, or as existing receptacles need replacement. This deficient	K 0914	**What corrective actions will be accomplished for those residents found to have been affected by this deficient practice?** The receptacle in room 303 has been replaced with a hospital grade receptacle. No other issues identified. **2. How will you identify other residents that have the potential to be affected by this deficient practice** This deficient practice could affect the two residents residing in room 303. All receptacles were checked to ensure meet the hospital grade requirement by the maintenance director.	07/23/2024

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	practice could affect 2 residents in Room 303. Findings include: Based on review of "Receptacle Testing" documentation dated 04/11/24 with the Executive Director and the Maintenance Director during record review from 9:30 a.m. to 12:20 p.m. on 06/26/24, electrical receptacles in an outlet box in resident sleeping Room 303 failed annual inspection and testing and was listed as "To be replaced Bed Top Corner" for "If Fail: Corrective Action". Based on interview at the time of record review, the Maintenance Director stated he was unsure if the receptacles which failed the 04/11/24 annual inspection were replaced with hospital-grade receptacles. Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 4:15 p.m. on 06/26/24, all electrical receptacle outlet boxes in Room 303 were not hospital grade. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		**3. What measures will be put in place or what systemic changes will be made to ensure that this deficient practice does not recur?** The maintenance department to be in-serviced on ensuring all receptables are tested routinely and replaced with hospital grade receptacles. The maintenance director or designee will audit weekly to ensure receptables are in compliance. Audits will be conducted each week x 4, then monthly x4, then as needed if no trends are identified. **4. 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?** A Electrical systems qapi Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	