STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155003	A. BUILDING -- B. WING	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MASON HEALTH CARE CENTER	900 PROVIDENT DRIVE WARSAW, IN 46580

(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: 11/02/22 Facility Number: 000003 Provider Number: 155003 AIM Number: 100290600 At this Emergency Preparedness survey, Mason Health Care Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 115 certified beds. At the time of the survey, the census was 86. Quality Review completed on 11/10/22	E 0000	The creation and submission of Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation or regulation. We are requesting paper compliance. Please see supporting documentation attached.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rukiya Brooks	Administrator	11/23/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in	E 0004	1. what corrective action(s) will be accomplished for those residents found to have been	11/22/2022

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	accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 11/02/22 at 10:01 a.m., the EEP cover page showed the last review date was 01/01/20, no other documentation could be found to show the EPP was reviewed and updated within the last year. Based on an interview during records review, the Administrator and Maintenance Director stated the documentation to show the EEP was reviewed or updated within the last year could not be found. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		affected by the deficient practice; The emergency preparedness plan has been reviewed and updated by management and all staff members. We have updated every preparedness book in the building. 2. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Emergency preparedness plan was reviewed by all staff to be updated into current status. 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The emergency preparedness plan will be reviewed annually with all staff. 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; and The emergency preparedness book will be placed at all nursing stations and reviewed annually by	

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

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	ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Policies and Procedures at least annually in accordance with 42 CFR	E 0013	1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	11/22/2022

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	483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 11/02/22 at 10:01 a.m., the EEP cover page showed the last review date was 01/01/20, no other documentation could be found to show the EPP Policies and Procedures were reviewed and updated within the last year. Based on an interview during records review, the Administrator and Maintenance Director stated the documentation to show the EEP Policies and Procedures were reviewed or updated within the last year could not be found. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		All staff have been updated on the policy and procedures in the emergency preparedness book. 2. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The facility will train staff annually on policies and procedures. All new hires will also be trained at the date of hire. 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All emergency preparedness binders will be updated annually. As updated, staff will be trained on new updates. 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; and Emergency preparedness book will be reviewed annually	

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E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 11/02/22 at 10:01 a.m., the EEP cover page showed the last review date was 01/01/20, no other documentation could be found to show the EPP Communication Plan was reviewed and updated within the last year. Based on an interview during records review, the Administrator and Maintenance Director stated the documentation to show the EEP Communication Plan was reviewed or updated within the last year could not be found.	E 0029	1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All staff has been updated on the emergency preparedness plan. Staff has been instructed on where to find the policy and procedures. 2. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The facility will continue to train and update staff on the policy and procedures. 3. what measures will be put	11/22/2022

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	This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		into place and what systemic changes will be made to ensure that the deficient practice does not recur; The facility will annually review and update the emergency preparedness binder. 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; and The facility will review the policies and procedures annually.	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must			

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	develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):]			

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	Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Training and Testing Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 11/02/22 at 10:01 a.m., the EEP cover page showed the last review date was 01/01/20, no other documentation could be found to show the EPP Training and Testing Plan was reviewed and updated within the last year. Based on an interview during records review, the Administrator and Maintenance Director stated the documentation to show the EEP Training and Testing Plan was reviewed or updated within the last year could not be found. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0036	1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; An in-service was completed on 11-16-22 and staff signed the training sheet. 2. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The facility will continue to complete all staff in-service and training annually. 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The facility will have continuous all staff training about the emergency preparedness.	11/16/2022

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			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; and The management team's annual review of the emergency preparedness plan.	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency			

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	preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers,			

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	consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.			

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	(ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting			

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	and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect	E 0037	1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The facility will continue all staff training annually. New hires will be trained at the date of hire. 2. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;	11/22/2022

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	all residents in the facility. Findings include: Based on records review with Maintenance Director on 11/02/22 at 10:31 a.m., no documentation of annual EEP staff training and no documentation to show staff could demonstrate knowledge of the EPP was available for review. Based on an interview at the time of records review, the Maintenance Director stated the annual EEP staff training could not found. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		The facility will complete annual all staff training. 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff training will occur annually to review emergency preparedness. 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; and Management team will review the policies and procedures of the emergency preparedness plan annually.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/02/22 Facility Number: 000003 Provider Number: 155003 AIM Number: 100290600	K 0000	The creation and submission of Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation or regulation. We are requesting paper compliance. Please see supporting documentation attached.	

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	At this Life Safety Code survey, Mason Health Care 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 (000) construction and was fully sprinklered. The original building consists of the 100, 200, 300, and center service hall. An addition was built in 2008 consisting of the 400 hall and therapy center. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The building is partially protected by a 50 kW Natural Gas-powered emergency generator. The facility has a capacity of 115 and had a census of 86 at the time of this survey. All areas where the residents have customary access were sprinklered. The facility had two detached sheds providing facility services including the storage of activity supplies, maintenance supplies and housekeeping supplies which were not sprinklered. Quality Review completed on 11/10/22			
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:			

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	CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.			

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	18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 3 of 4 exit doors 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 55 residents in three halls. Findings include: Based on observation with the Maintenance Director on 11/02/22 between 11:00 a.m. and 1:13 p.m., the exit doors on 100, 300, and 400 halls were marked as a facility exit, were magnetically locked, and could be opened by entering a four-digit code on the access control pads, but the code was not posted at the exits. Based on interview at the time of observation, the Maintenance Director agreed	K 0222	1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The individual codes were placed on the key pads on the exit doors for 100, 300, and 400 halls. Please see attached pictures of corrective action. 2. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Other exit doors were checked to ensure that the codes were on the access control pads. The maintenance department will	11/16/2022

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	the codes to open the exit doors were not posted by the access control pads. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		check doors weekly for the next 6 week starting 11-16-22. Please see attached audit tool. 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The codes have been placed by the doors and will be monitored weekly for the next 6 weeks by the maintenance department. 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; and The maintenance department will be using an audit tool to monitor the doors.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer			

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	patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure staff had access to the shutoff switch for 1 of 1 cook tops in the therapy gym. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect five residents in the therapy gym. Findings include:	K 0324	1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The therapy staff has been trained to shut off the breaker when the stove is not in use. A sign has been placed above the stove indicating where the breaker is located. Please see attached picture of breaker location and in-service training on stove. 2. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The therapy staff was trained on shutting off the breaker to stove when not in use and the location of breaker. 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not	11/16/2022

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	Based on observation with the Maintenance Director on 11/02/22 at 12:14 p.m., there was a cooktop in the therapy gym that was separated from the corridor, but staff were unable to deactivate the cooktop from power. Based on interview at the time of observation, the Maintenance Director was asked if staff were able to deactivate the cooktop and lock the switch. The Maintenance director stated the shut off switch is in the electrical room in a braker box, but staff did not have access to the braker box. The finding was reviewed with Maintenance Director and Adminstrator during the exit conference. 3.1-19(b)		recur; Therapy staff was trained on 11-16-22 on proper procedure of stove usage in the therapy gym. Please see attached in-service training tool. 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; and The maintenance staff will check stove weekly for the next 6 weeks. -	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room where oxygen transferring takes place, was provided with properly working mechanical ventilation. NFPA 99 2012 edition, 11.5.2.3.1 (2) requires	K 0927	1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice	11/04/2022

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	oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical exhaust to maintain a negative pressure in the space continuously. This deficient practice could affect up to 20 residents in one smoke compartment. Findings include: Based on observation during a tour of the facility the Maintenance Director on 11/02/22 at 11:28 a.m., the oxygen storage/transfer room contained large liquid oxygen tanks. There was a vent to the outside with a mechanically ventilated exhaust fan, but there was no pull of air from the vent. It was determined the fan motor was not properly working. Based on interview at the time of observation, the Maintenance Director stated the Maintenance Tech looked at the fan motor and replaced the belt, but the Tech stated the fan motor would not turn on. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		On November 4th, the maintenance department installed a new motor to exhaust system for the oxygen room. Please see attached picture and video of exhaust system working. 2. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Maintenance repaired and installed new motor to exhaust system on 11-4-22. Please see attached picture and video of exhaust system working. 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance department will monitor and check system weekly for the next 6 weeks. This will also be monitored through our maintenance TELS computer program. 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; and Maintenance will continue to	

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			monitor weekly for the next 6 weeks.	