STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING -- B. WING	02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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 Dates: 02/01/24 - 02/02/24 Facility Number: 000189 Provider Number: 155292 AIM Number: 100267330 At this Emergency Preparedness survey, American Village was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 150 certified beds. At the time of the survey, the census was 120. Quality Review completed on 02/07/24	E 0000	This Plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report. American Village respectfully requests consideration for a desk review of this plan of correction.	
E 0031 SS=C Bldg. --	403.748(c)(2), 416.54(c)(2), 418.113(c)(2), 441.184(c)(2), 482.15(c)(2), 483.475(c)(2), 483.73(c)(2), 484.102(c)(2), 485.625(c)(2), 485.68(c)(2), 485.727(c)(2), 485.920(c)(2), 486.360(c)(2), 491.12(c)(2), 494.62(c)(2) Emergency Officials Contact Information §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gina Couch	Executive Director	03/04/2024

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

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	155292	A. BUILDING -- B. WING	02/02/2024

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AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

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	plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency.			
	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan included all applicable sources of assistance. This deficient practice could affect all occupants. Findings include: Based on records review and interview with the with the Maintenance Director, Administrator and	E 0031	E031 Emergency Officials Contact Information **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** The Long-Term Care Ombudsman contact information including telephone number was added to	03/08/2024

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	Executive Director on 02/01/24 between 9:10 a.m. and 12:45 p.m., documentation of the communication plan part of the facility's emergency operations plan reviewed did not include specific contact information, including telephone number, for notification of the State Long Term Care Ombudsman. The Administrator and ED agreed documentation for the communication plan part of the program did not include specific contact information for the office of the State Long Term Care Ombudsman. The ED searched through the emergency preparedness program manual throughout the afternoon, however the aforementioned contact information for the State Long Term Care Ombudsman could not be located in the plan at the time of the survey. This finding was acknowledged by the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator, Executive Director, and Reginal Vice President all present.		the emergency preparedness communication plan. **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** No residents were affected by the alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The Administrator and Executive Director have been educated regarding the emergency preparedness communication plan requirement of having the state ombudsman contact information including telephone number. An administrative audit tool will be completed to ensure the state ombudsman contact information will continue to be located in the Emergency operations plan. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place** The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and	

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			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 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 Dates: 02/01/24 - 02/02/24 Facility Number: 000189 Provider Number: 155292 AIM Number: 100267330 At this Life Safety Code survey, American Village 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. American Village consists of two wings, Harrison Hall which is one story and Washington Manor which is two stories. This facility was determined to be of Type III (211) construction and was fully sprinklered. The east wing of the second floor of Washington Manor houses the Moving Forward	K 0000	This Plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report. American Village respectfully requests consideration for a desk review of this plan of correction.	

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	rehab wing. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in 59 of 82 resident sleeping rooms. The facility has smoke detectors hard wired to the facility's electrical system in 23 of 82 resident sleeping rooms. The facility has a capacity of 150 and had a census of 120 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for a detached storage and repair shed. Quality Review completed on 02/07/24			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General 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. 1) Based on observation and interview, the facility failed to ensure 1 of 1 electric range in the therapy area was free of combustible material and other debris. LSC 19.1.1.3.1 states all health care facilities shall be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect 8 residents and staff in the therapy area. Findings include:	K 0100	K100 General Requirements - Other **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** The electric range in the therapy area power supplied was immediately shut off and the paper and wood products in direct contact were removed. The smoke barrier doors on 200	03/08/2024

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	Based on observations and interview during a tour of the facility with the Maintenance Director and Administrator on 02/01/24 between 12:45 p.m. and 4:30 p.m., the electric range in the therapy area, with power supplied to the appliance, had placed on the electric burners, paper and wood products in direct contact with the burners failing to minimize the possibility of a fire emergency relating to the aforementioned appliance. The MD and Administrator acknowledged the condition stating that the staff know better than to do this. This finding was acknowledged by the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator, Executive Director, and Reginal Vice President all present. 3.1-19(b) 2) Based on observation and interview, the facility failed to maintain latching hardware on 1 of 6 smoke barrier doors per 4.6.12.3. 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 15 residents and staff in the 200 Hall. Finding include: Based on observations and interview during a tour of the facility with the Maintenance Director and Administrator on 02/01/24 between 12:45 p.m. and 4:30 p.m., the smoke barrier doors equipped with latching hardware, on the 200 Hall near RR# 201 failed to latch when closed. This finding was acknowledged by the		hall latching hardware was adjusted to ensure the 200 hall smoke barrier doors near room 201 latch when closed. **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** No residents were affected by the alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The Therapy department has been educated on facilities practice of the electric range power being off when not in use and to not have wood or paper items on range. The Maintenance Director educated regarding smoke barrier doors latching when closing. A maintenance audit tool will be completed to ensure the smoke barrier doors latch when closing and wood or paper items on range in therapy gym. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place**	

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	Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator, Executive Director, and Reginal Vice President all present. 3.1-19(b)		The POC QAPI Tool will be utilized by ED/designee 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 0211 SS=E 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 observation and interview, the facility failed to ensure 1 of over 8 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 over 10 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director and Administrator on 02/01/24 between 12:45 p.m. and 4:30 p.m., the exit discharge sidewalk leading from the dining area exit (marked a facility exit) into the courtyard contained several crates and a	K 0211	K211 Means of Egress - General **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** The charcoal grill and crates were removed from the exit discharge sidewalk leading from the dining area exit into the courtyard. **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** No residents were affected by the	03/08/2024

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	charcoal grill all placed and being stored on the sidewalk component of the exit discharge. The MD and Administrator acknowledged that the exit leading to the public way was obstructed stating that it would need to be cleared. This finding was acknowledged by the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator, Executive Director, and Reginal Vice President all present. 3.1-19(b)		alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The Maintenance Director educated regarding means of egress being maintained free of all obstructions. A maintenance audit tool will be completed to ensure the means of egress leading from dining room to courtyard be free of all obstructions. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place** The POC QAPI Tool will be utilized by ED/designee 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 0222 SS=F	NFPA 101 Egress Doors			

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Bldg. 01	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 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			

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	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 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 2 of over 8 exterior exit doors were readily accessible and able to open on first try. This deficient practice could affect 30 or more occupants in the facility. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director and Administrator on 02/01/24 between 12:45 p.m. and 4:30 p.m., the (1) 300 Hall exit door near RR# 314 failed to open when attempted multiple times. The aforementioned door, on the Memory Care Hall, was secured with a magnetic locking device which failed to open the door. The MD believed the reason the door wouldn't open was due to a	K 0222	K222 – Egress Doors **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** The 300 hall exit door was inspected by IEI and the issue was corrected before the life safety survey exit. The dining room exit door to the courtyard was adjusted and corrected. The 100 hall signage of push here and alarm will sound signage has been removed. **How other residents having the**	03/08/2024

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	drainage issue outside the door. A quote was provided from a contractor dated 07/31/23 showing an awareness that the aforementioned door had an issue. The facilities Fire Alarm contractor was called at the time of the survey and notified of the issue with the magnetic lock. The facility managed to force the door open, disconnect the magnetic locking device and position personnel at the location to prevent elopement. The issue was corrected before the Survey Exit the next day. (2) The Dining Exit, marked a facility exit, took excessive force to open. The MD stated that "you have to lift up and push" to open the door because it was "rusted at the bottom and needs replaced." This finding was acknowledged by the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator, Executive Director, and Reginal Vice President all present. 2. The facility failed to ensure the delayed egress locking arrangements were installed in accordance with 7.2.1.6.1(3) in 3 of 12 exits. 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		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken** No residents were affected by the alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The Maintenance Director educated regarding exterior exit doors to be readily accessible and able to open. A maintenance audit tool will be completed to ensure the 300 hall exit door and dining room exit door to be readily accessible and able to open. A maintenance audit tool will be completed to ensure the signage of “Push here alarm will sound” has been removed from the exit doors that do not have the release. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place** The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year	

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	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 deficient practice could all residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director and Administrator on 02/01/24 between 12:45 p.m. and 4:30 p.m., several exit doors throughout the facility, such as the 100 hall exit, had signage on the doors reading "Push Here Alarm will Sound" however the doors did not have a functioning delayed egress mechanism. The doors throughout the facility were secured with an electronic keypad not 15 second delayed egress. When tested for 15 second delayed egress the exit doors did not appear to release. The MD and Administrator speculated that the aforementioned signage was very old and might need to be removed. This finding was acknowledged by the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator, Executive Director, and Reginal Vice President all present. 3.1-19(b)		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 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life			

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AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, interview and observation, the facility failed to ensure documentation for the preventative maintenance of 59 of 59 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 record review of the document entitled "Battery-operated smoke detector inspection report - 2023" and interview with the Maintenance Director, Administrator and Executive Director on 02/01/24 between 9:10 a.m. and 12:45 p.m., there was no itemized list or record of when the batteries in the resident room battery operated smoke alarms were installed or replaced. Based on interview at the time of record review, the Maintenance Director stated that he was not keeping records of when the batteries were being replaced on the battery-operated smoke detectors. Manufacturer recommendations on the sticker behind the smoke detector provided for reviews called for weekly testing and monthly cleaning. Furthermore, the MD stated he was not keeping records indicating the monthly cleaning of the battery-operated smoke detectors. Based on	K 0300	K300 Protection - Other **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** All 59 of 59 smoke alarms batteries were replaced with date recorded. All 59 of 59 smoke detectors received a monthly cleaning per manufacturer recommendations. **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** No residents were affected by the alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The Maintenance Director has been educated on battery operated smoke alarms record keeping of when batteries were installed or replaced along with monthly cleaning. A maintenance audit tool will be completed to ensure all battery-operated smoke alarms batteries were replaced along with monthly cleaning in accordance	03/08/2024

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	observations made during a tour of the facility, 59 of 82 resident sleeping rooms surveyed within the facility did indeed have battery operated smoke detectors. This finding was acknowledged by the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator, Executive Director and Reginal Vice President all present. 3.1-19(b)		with the manufacturer's guidelines. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place** The POC QAPI Tool will be utilized by ED/designee 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 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of			

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	hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 1 400 Hall linen closets was separated from other corridor by smoke resistant doors. This deficient practice could affect 20 plus residents and staff in one smoke compartment. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director and Administrator on 02/01/24 between 12:45 p.m. and 4:30 p.m., the corridor door to the 400-hall linen closet, equipped with a self-closing device had three 3/8th inch holes near the doorknob. Based on interview at the time of the observation, the MD and Administrator agreed the linen closet corridor door would not resist the passage of smoke. This finding was acknowledged by the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the	K 0321	K321 – Hazardous Areas - Enclosure What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice The 400-hall linen closet door has been repaired. 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 No residents were affected by the alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur	03/08/2024

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	Maintenance Director, Administrator, Executive Director, and Reginal Vice President all present. 3.1-19(b)		The Maintenance Director educated regarding the 400 hall linen closet door to be separated from other corridor by smoke resistant doors. A maintenance audit tool will be completed to ensure the 400 hall linen closet door to be free of holes. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place • The POC QAPI Tool will be utilized by ED/designee 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 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			

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	cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 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 area. 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 8 residents and	K 0324	K324 Cooking Facilities **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** The electric range in the therapy area power supplied was immediately shut off. **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** No residents were affected by the alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**	03/08/2024

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	staff in the therapy area. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director and Administrator on 02/01/24 between 12:45 p.m. and 4:30 p.m., there was an electric range in the therapy area that was powered on and not in use. The Maintenance Director was asked if staff knew how to deactivate the range when not in use and he was unsure. The Maintenance Director stated there was a shut off switch to the electric range. This finding was acknowledged by the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator, Executive Director, and Reginal Vice President all present. 3.1-19(b)		The Therapy department has been educated on facilities practice of the electric range power being off when not in use. A maintenance audit tool will be completed to ensure the range in therapy gym to be off when not in use. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place** The POC QAPI Tool will be utilized by ED/designee 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=C 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			

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	Based on observation and interview, the facility failed to maintain the fire alarm system to assure 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, 14.1.1. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director and Administrator on 02/01/24 between 12:45 p.m. and 4:30 p.m., the date on the fire alarm control panel was incorrect. The display on the main fire alarm control panel indicated the a date of 6/11 and the actual date was 02/01/24. Based on interview at the time of observation, the MD indicated he was unaware of the discrepancy and would contact the alarm company to have the displayed date corrected. This finding was acknowledged by the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator, Executive Director, and Reginal Vice President all present. 3.1-19(b)	K 0345	**K345 – Fire Alarm System – Testing and Maintenance** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** The fire alarm date has been reset and is correct. **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.** No residents were affected by the alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The Maintenance Director has been trained in ensuring the fire alarm panel has the correct date. A maintenance audit tool will be completed to ensure the date is correct on the fire alarm panel. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place** The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year	03/08/2024

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			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 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure that a complete automatic sprinkler system or documentation of fire retardant material was provided for 1 of 1 canvas canopies. NFPA 13-2010 Edition, Section 8.15.7.1 states sprinklers shall be installed under exterior roofs, canopies, porte-cocheres, balconies, decks, or similar projections exceeding 4 ft. (1.2 m) in	K 0351	**K351 Sprinkler System - Installation** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** The canvas canopy attached to	03/08/2024

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	width. Section 8.15.7.2 states sprinklers shall be permitted to be omitted where the canopies, roofs, porte-cocheres, balconies, decks, or similar projections are constructed with materials that are noncombustible or limited-combustible, or fire retardant. Textiles such as canvas used as an awning shall meet NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice could affect at least 20 residents evacuating the facility. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director and Administrator on 02/01/24 between 12:45 p.m. and 4:30 p.m., there was a canvas canopy attached to the building outside the 100 Hall East Exit which measured approximately 20'X12', which was not sprinkled. Based on record review no documentation could be provided to show the canvas was inherently flame retardant. At the exit conference on 02/02/24 the ED and Regional Vice President stated that the canopy would likely be removed. Following the survey exit, a document was emailed to the surveyor implying that the aforementioned canopy was in compliance and was inherently flame retardant. It could not be determined by the surveyor that the post survey documentation was applicable to the aforementioned canopy. This finding was acknowledged by the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator, Executive Director, and Reginal Vice President all present. 3.1-19(b)		the building outside the 100 hall east exit has been removed. **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.** No residents were affected by the alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The Maintenance Director has been trained in ensuring that outside canopies must have documentation on fire retardant materials. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place** The POC QAPI Tool will be utilized by ED/designee 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 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 record review and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 5.1.1.1.3 states sprinklers manufactured using fast-response elements that have been in service for 20 years shall be replaced, or representative samples shall be tested and then retested at 10-year intervals. NFPA 25, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard.	K 0353	**K353 Sprinkler System – Maintenance and Testing** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** The random sprinkler head sampling was inspected on December 19, 2023. There are two of every type and kind of sprinkler head located in the spare sprinkler cabinet along with a list of each type of sprinkler head in this facility. **How other residents having the potential to be affected by the**	03/08/2024

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	Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on records review and interview with the with the Maintenance Director, Administrator and Executive Director on 02/01/24 between 9:10 a.m. and 12:45 p.m., deficiencies were noted for the facility's sprinkler system. The "Deficiencies Summary" section of the 08/2/2023 sprinkler system inspection report stated, "Sprinklers with fast response elements 20 years old or more replaced or successfully sample tested in the last 10 years?" Followed by "No record of random sample on file." Based on interview at the time of record review, the MD and ED stated the facility was unaware of the current status regarding this reported deficiency. This finding was acknowledged by the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator, Executive Director, and Reginal Vice President all present. 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection		**same deficient practice will be identified and what corrective action(s) will be taken.** No residents were affected by the alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The Maintenance Director has been educated on record keeping and on regulations of testing/inspecting sprinkler system. The Maintenance Director has been educated on storing at least 2 spare sprinkler heads for each sprinkler head type in this facility along with a list of the sprinkler heads being utilized. A maintenance audit tool will be completed annually to ensure the sprinkler system are working properly and inspected by certified company. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place** The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year	

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AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

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	Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director and Administrator on 02/01/24 between 12:45 p.m. and 4:30 p.m., there was one spare sprinkler cabinet in the riser room that included only 5 spare sprinklers. Furthermore, it did not appear to the surveyor that the 5 provided spare sprinkler heads represented 2 of every type and kind of sprinkler head in the facility. No list of each type and kind of sprinkler head which populates the facility was available at the spare sprinkler cabinet for verification. This finding was acknowledged by the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator, Executive Director, and Reginal Vice President all present. 3.1-19(b)		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 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the therapy area was installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice could affect 10 residents and staff in the Therapy area. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director and Administrator on 02/01/24 between 12:45 p.m. and 4:30 p.m., an ABC portable fire extinguisher in the therapy area, near the range, was sitting on the floor unsecured. This finding was acknowledged by the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator, Executive Director, and Reginal Vice President all present. 3.1-19(b)	K 0355	K355 Portable Fire Extinguishers **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice** The portable fire extinguisher located in the therapy gym was secured to the wall. **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** No residents were affected by the alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur** Maintenance Director has been educated on that all portable ABC fire extinguishers are to be either securely on a hanger intended for the extinguishers, in the bracket supplied by the extinguisher manufacture, in a bracket approved for such purpose or in a	03/08/2024

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			wall cabinet/wall recess. A maintenance audit tool will be completed to ensure that portable fire extinguishers are securely attached to 1 of the 3 approved means. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put in place** The POC QAPI Tool will be utilized by ED/designee 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			

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	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. 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 all corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 6 staff and 15 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director and Administrator on 02/01/24 between 12:45 p.m.	K 0363	K363 – Corridor Doors What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice The storage room door on Rehab Hall hardware has been adjusted to SC and latch. The Double doors from kitchen in the dining area have been adjusted to SC and latch. The Kitchen into service hall door	03/20/2024

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	and 4:30 p.m., the following corridor doors failed to latch positively into their respective door frames: a) Storage room door on Rehab Hall with a self-closing device, failed to SC and latch. b) Double doors from the kitchen into the dining area, with a self-closing device, failed to SC and latch. c) Kitchen into service hall door, the MD stated the doors were being replaced. d) Ice Roo, door into the dining area, with a self-closing device, failed to SC and latch. The door appears to be dragging significantly on the floor. e) The Clean Linen closet door on the 200 Hall not latching. This finding was acknowledged by the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator, Executive Director, and Reginal Vice President all present. 2. Based on observation and interview, the facility failed to ensure 2 of over 50 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 12 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director and Administrator on 02/01/24 between 12:45 p.m. and 4:30 p.m., the corridor door to (1) the Small Therapy on Rehab Hall was propped open with a set of weights. And (2) the Unit Managers Office		is scheduled to be delivered and installed when received by March 20, 2024. The Ice room door into the dining room hardware has been adjusted to SC, latch and not drag. The clean linen closet door on 200 hall hardware has been adjusted to latch. 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 No residents were affected by the alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur The Maintenance Director educated regarding all corridor doors to have no impediment to closing and latching into the door frame and would resist the passage of smoke. A maintenance audit tool will be completed to ensure the storage room door on rehab hall, double doors from kitchen into the dining area, kitchen into service hall door, ice room door into the dining area and the clean linen closet doors to latch.	

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	door was propped open with a trashcan. The aforementioned doors were equipped with self-closing devices. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned corridor doors would not close unless the obstructions were first moved. 3.1-19(b)		How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place • The POC QAPI Tool will be utilized by ED/designee 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 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 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. 1. Based on observation and interview, the facility failed to ensure all smoke barriers walls were	K 0372	K372 Subdivision of Building Spaces – Smoke Barrier	03/08/2024

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	protected to maintain the smoke resistance of each smoke barrier. LSC 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. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 16 residents and staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director and Administrator on 02/01/24 between 12:45 p.m. and 4:30 p.m., the (1) corridor wall near the double door set on the Rehab Hall had a 4"X4" hole and not providing completely sealed walls which would resist the passage of smoke. The MD stated he was unaware of the hole which was behind the door. And (2) approximately a 20"X20" hole in the ceiling of the Sprinkler Riser Room was observed. This finding was acknowledged by the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator, Executive		Construction **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** The corridor wall near the double door set on the rehab hall 4x4” hole has been sealed to not allow the passage of smoke. The hole in the sprinkler rising room that measured approximately 20x20” has been repaired. The several penetrations between 1” and 3” located near the service hall entrance along the wall have been repaired. **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** No residents were affected by the alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The Maintenance Director educated regarding smoke barrier walls to be free of holes. A maintenance audit tool will be completed to ensure the smoke barrier wall near double door- on	

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	Director, and Reginal Vice President all present. 2. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of over 5 smoke barriers walls were protected to maintain the smoke resistance of each smoke barrier. LSC 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. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 16 residents and staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director and Administrator on 02/01/24 between 12:45 p.m. and 4:30 p.m., several unsealed penetrations were discovered in the smoke barrier wall above the drop ceiling near the service hall entrance. Several penetrations, most having wire inserted and measuring between 1 inch and 3 inches were observed along the wall.		rehab hall hole is sealed, the sprinkler riser room to be free of holes and the service hall entrance along the wall penetrations are sealed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place** The POC QAPI Tool will be utilized by ED/designee 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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	This finding was acknowledged by the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator, Executive Director, and Reginal Vice President all present. 3.1-19(b)			
K 0511 SS=E 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 service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation, the facility failed to ensure 1 of 1 electrical junction box above the drop ceiling was maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect staff and 13 residents and staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director and Administrator on 02/01/24 between 12:45 p.m. and 4:30 p.m., an electrical junction box above the ceiling near the service hall entrance did not	K 0511	K511 – Utilities – Gas and Electric **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** The electrical junction box above the ceiling near the service hall entrance has been covered and no longer exposes electrical wiring. **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** No residents were affected by the alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice.	03/08/2024

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	contain a cover and had exposed electrical wiring in the box. Based on interview at the time of the observations, the Maintenance Director acknowledged the electrical junction box was not provided with a cover and had exposed wires. This finding was acknowledged by the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator, Executive Director, and Reginal Vice President all present. 3.1-19(b)		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The Maintenance Director educated regarding electrical junction box to be maintained in a safe operating condition. A maintenance audit tool will be completed to ensure the electrical junction box above the ceiling near the service hall entrance to be covered with no exposed electrical wiring. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place** The POC QAPI Tool will be utilized by ED/designee 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 0741 SS=F Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions:			

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	(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation, records review, and interview, the facility failed enforce 1 of 1 non-smoking policies. This deficient practice could affect everyone in the facility. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director and Administrator on 02/01/24 between 12:45 p.m. and 4:30 p.m., smoking on and in the property was evident due to (1) the fresh smell of cigarette smoke in the restroom attached to the Rehab common lounge area. The surveyor visited this	K 0741	K741 – Smoking Regulations **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** The cigarette butts on the ground in the smoking area have been removed. The crates were removed from the entrance door of the building. **How other residents having the potential to be affected by the same deficient practice will be**	03/08/2024

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	restroom during the record review portion of the survey and experienced the presence of cigarette smoke in the aforementioned restroom. Additionally, during the facility tour in the aforementioned lounge area, the smell of cigarette smoke was evident. The facilities provided smoking policy states under General Guidelines, line one, "There will be no smoking in the facility by staff or visitors." Furthermore, (2) In the facilities designated smoking area, more than 50 cigarette butts were on the ground throughout the area. (3) A staff person was observed smoking in the vicinity of the 1 designated smoking area and sitting on crates up against the building well within 8 feet of the facility entrance door. This finding was acknowledged by the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator, Executive Director, and Reginal Vice President all present. 3.1-19(b)		**identified and what corrective action(s) will be taken** No residents were affected by the alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** All Staff educated regarding the facilities smoking policy. A maintenance audit tool will be completed to ensure there are no cigarette butts in the smoking area nor any crates against the facility back entrance door. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place** The POC QAPI Tool will be utilized by ED/designee 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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	155292	A. BUILDING 01 B. WING	02/02/2024

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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 fire door assembly was completed in accordance of 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 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	K 0761	K761 – Maintenance, Inspection and Testing - Doors **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** The oxygen transfilling room door has received an annual inspection. **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** No residents were affected by the alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The Maintenance Director educated regarding keeping written records of oxygen door inspection. A maintenance audit tool will be completed to ensure the oxygen transfilling room door is on an annual inspection. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	03/08/2024

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	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 20 residents. Findings include: Based on records review and interview with the with the Maintenance Director, Administrator and Executive Director on 02/01/24 between 9:10 a.m. and 12:45 p.m., no documentation of an annual inspection for the fire door assembly at the Oxygen Transfilling room was available for review. Based on observation during the tour the Oxygen Transfilling room has one 90-minute fire door assembly. Based on interview at the time of records review and observation, the MD stated the annual fire door inspection was not completed within the last year and was previously unaware a fire door inspection was needed on the Transfilling Room door. This finding was acknowledged by the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator, Executive Director, and Reginal Vice President all present.		**recur, ie., what quality assurance program will be put into place** The POC QAPI Tool will be utilized by ED/designee 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 0781 SS=E Bldg. 01	3.1-19(b) NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation and interview, the facility failure to ensure 1 of 1 portable space heaters were not used in the facility. This deficient practice could affect up to 3 residents, staff and visitors. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director and Administrator on 02/01/24 between 12:45 p.m. and 4:30 p.m., a portable space heater was in use in the Therapy Office. Based on interview at the time of the observations, the Maintenance Director agreed a space heater was being used and was in violation of the facilities policy regarding space heaters. Based on interview during records review the MD and ED stated that portable space heaters were not allowed anywhere in the facility per the company policy. This finding was acknowledged by the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator, Executive Director, and Reginal Vice President all present.	K 0781	K781 Portable Space Heaters **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** The space heater in the therapy gym was immediately removed. **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** No residents were affected by the alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The Maintenance Director has been educated on facilities practice of not using space	03/08/2024

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	3.1-19(b)		heaters. A maintenance audit tool will be completed to ensure there are no portable space heaters. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place** The POC QAPI Tool will be utilized by ED/designee 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 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms			

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	(outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure power strips in the resident rooms were of UL rating of 1363A or 60601-1. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice affects 10 residents and staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director and Administrator on 02/01/24 between 12:45 p.m. and 4:30 p.m., the power strips being used in RR# 201 and RR# 210 lacked a UL rating of 1363A or 60601-1 label. Documentation provided during records review for facility used power strips did not indicate that they met the aforementioned requirements for use. A handwritten "1364A" was placed on the provided documentation. However, the manufacturer supplied documentation did not seem to indicate that the power strips relating to the supplied documentation met the requirement. Other power strips were observed in the resident	K 0920	K920 – Electrical Equipment – Power Cords and Extension Cords **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** The power strips being used in room 201 and 210 have been replaced by power cord that meets the 1363A or 60601-1 requirement. **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** No residents were affected by the alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The Maintenance Director has been educated on facilities	03/08/2024

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	rooms and it was unclear if they met the UL rating of 1363A or 60601-1 rating. This finding was acknowledged by the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator, Executive Director, and Reginal Vice President all present. 3.1-19(b)		practice using power strips that meet the 1363A or 60601-1 requirement. A maintenance audit tool will be completed to ensure the power strips in rooms 201 and 210 have been replaced with an approved power strip. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place** The POC QAPI Tool will be utilized by ED/designee 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 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			

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	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 trans-filling rooms were separated from other areas in the facility in a room that is protected with a one-hour fire-resistive construction in accordance with 2012 NFPA 99 11.5.2.3.1(1). This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director and Administrator on 02/01/24 between 12:45 p.m. and 4:30 p.m., the oxygen trans-filling room had a hole in the ceiling measuring approximately 1 inch in diameter. The Maintenance Supervisor stated he was unaware of the hole. The Administrator investigated the room and verified the presence of the aforementioned hole in the ceiling. This finding was acknowledged by the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator, Executive Director, and Reginal Vice President all present. 3.1-19(b)	K 0927	K927 – Gas Equipment – Transfilling Cylinders **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** The oxygen trans-filling room 1 inch in diameter hole in the ceiling has been repaired. **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** No residents were affected by the alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The Maintenance Director educated regarding oxygen room ceiling to be free of holes. A maintenance audit tool will be completed to ensure the oxygen room ceiling to be free of holes. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality**	03/08/2024

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			assurance program will be put into place The POC QAPI Tool will be utilized by ED/designee 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.	