STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155525	A. BUILDING -- B. WING	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SHADY NOOK CARE CENTER	36 VALLEY DR LAWRENCEBURG, IN 47025

(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: 09/14/22 Facility Number: 000304 Provider Number: 155525 AIM Number: 100266810 At this Life Safety Code survey, Shady Nook Care Center was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 94 certified beds. At the time of the survey, the census was 80. Quality Review completed on 09/22/22	E 0000		
E 0018 SS=C Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [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			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155525	A. BUILDING -- B. WING	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SHADY NOOK CARE CENTER	36 VALLEY DR LAWRENCEBURG, IN 47025

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	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 [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice			

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	employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b) (2). This deficient practice could affect all occupants.	E 0018	The plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirement established by state and federal law. Attached for your review and	09/30/2022

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	Findings include: Based on review of the Emergency Preparedness plan on 09/14/22 between 10:00 a.m. and 1:15 p.m. with the Director of Maintenance and Administrator present, no policies and procedures that include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency was available for review. Based on interview at the time of record review, the Administrator confirmed there was no system to track the location of on-duty staff and sheltered residents in the event of an emergency in the available plan. This finding was reviewed with the Director of Maintenance and Administrator during the exit conference.		approval, is the completed plan of correction for the recent Life and Safety Code Survey, Event ID 5IVX21, conducted on September 14, 2022 at Shadynook Care Center. Please be advised that it is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective October 3. 2022. Shadynook Care Center also respectfully requests a desk review for this plan of correction. E 0018 It is the policy of Shadynook Care Center to have procedures to track the location of on-duty staff and sheltered patients in Shadynook's care. What corrective action will be accomplished for those residents found to be affected by the deficient practice? All residents have the potential to be affected by the alleged deficient practice. The Shadynook disaster plan has been revised to include an emergency plan for transfer and shelter of on-duty staff and sheltered residents. The disaster plan also includes the Skilled Nursing Care Evacuation procedure; including tracking of on-duty staff and residents. (See attachment of Emergency Preparedness Plan, Page 10; Item 7 and Page 12.	

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			How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. The corrective action for the deficient practice included revision of the disaster plan to include the emergency plan for transfer and shelter of on-duty staff and sheltered residents, tracking of on-duty staff and residents, as well as the Skilled Nursing Care evacuation procedure. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The staff were educated on the revised policy before or by September 30, 2022. (Attachment B) All new employees will undergo training during general orientation and ongoing in-services, as dictated by the facility, which will include the language of the revised disaster plan. How will the corrective action be monitored to ensure the deficient practice will not recur? The corrective action will be monitored by the Administrator or designee. Any areas of concern will be brought to the QA committee for review. And emergency preparedness will be	

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	155525	A. BUILDING -- B. WING	09/14/2022

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			reviewed at least annually and more often if indicated.	
E 0024 SS=C Bldg. --	403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 482.15(b)(6), 483.475(b)(6), 483.73(b)(6), 484.102(b)(5), 485.625(b)(6), 485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5) Policies/Procedures-Volunteers and Staffing §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [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 [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an			

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	emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness plan on 09/14/22 between 10:00 a.m. and 1:15 p.m. with the Director of Maintenance and Administrator present, the facility's plan did not address the use of volunteers in an emergency. Based on interview at the time of review, the Administrator confirmed the plan provided did not address the use of volunteers in an emergency. This finding was reviewed with the Director of Maintenance and Administrator during the exit conference.	E 0024	The plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirement established by state and federal law. Attached for your review and approval, is the completed plan of correction for the recent Life and Safety Code Survey, Event ID 5IVX21, conducted on September 14, 2022 at Shadynook Care Center. Please be advised that it is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective October 3. 2022. Shadynook Care Center also respectfully requests a desk review for this plan of correction. E 0024 It is the policy of Shadynook Care Center to have procedures for use of volunteers in an emergency or other emergency staffing strategy. What corrective action will be	09/30/2022

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			accomplished for those residents found to be affected by the deficient practice? No residents were affected by the alleged deficient practice. A policy and procedure have been developed that addresses the use of volunteers, staffing strategies, including the process and role of integration of State and federal designated health care professionals and to address surge needs during an emergency. (See attachment of Emergency Preparedness Plan, Page 8; Item 19 and Page 9; Item 1 and 8.) How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. The corrective action for this deficient practice included reviewing/revising the disaster plan to include a plan for use of volunteers, staffing strategies, integration of state/federal agencies during an emergency and/or during surge emergency needs. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The staff were educated on the revised policy before or by September 30, 2022. (Attachment B) All new employees will undergo	

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			training during general orientation and ongoing in-services, as dictated by facility, which will include the language of the revised disaster plan. How will the corrective action be monitored to ensure the deficient practice will not recur? The corrective action will be monitored by the administrator or designee.	
E 0035 SS=C Bldg. --	483.475(c)(8), 483.73(c)(8) LTC and ICF/IID Sharing Plan with Patients §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. Based on record review and interview, the facility lacked an emergency preparedness communication program that included a method	E 0035	The plan of correction constitutes the written allegation of compliance for the deficiencies	09/30/2022

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	for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness plan on 09/14/22 between 10:00 a.m. and 1:15 p.m. with the Director of Maintenance and Administrator present, the emergency preparedness communication plan failed to document a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives. Based on interview at the time of record review, the Administrator confirmed the documentation of the method to share information was not in the emergency preparedness plan. This finding was reviewed with the Director of Maintenance and Administrator during the exit conference.		cited. However, submission of this plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirement established by state and federal law. Attached for your review and approval, is the completed plan of correction for the recent Life and Safety Code Survey, Event ID 5IVX21, conducted on September 14, 2022 at Shadynook Care Center. Please be advised that it is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective October 3. 2022. Shadynook Care Center also respectfully requests a desk review for this plan of correction. E0035 It is the policy of Shadynook Care Center to develop and maintain an emergency preparedness communication plan that complies with the Federal and State and local laws. **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** No residents were affected by the alleged deficient practice. A policy and procedure have been developed that ensures families and representatives will be communicated with in an event of an emergency. Information will be included in the admission packet	

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			to ensure each new resident, their family, and/or representative is aware of the Emergency Preparedness plan and how this facility will ensure their safety during an emergency. **(See Attachment in Emergency Preparedness Page 9; Item 1 and Page 10; Item 3 and 6)** **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. The corrective action for this deficient practice included information added to the admission packet to ensure each new resident, their family and/or representative is aware of the Emergency Preparedness plan and how this facility will ensure safety during an emergency. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The Administrator or his/her designee will ensure that each current and new resident receives proper education. Any variances will be tracked and trended and reported to the QAPI committee. **How will the corrective action be monitored to ensure the deficient practice will not recur?**	

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/14/22 Facility Number: 000304 Provider Number: 155525 AIM Number: 100266810 At this Life Safety Code survey, Shady Nook 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 with a partial basement/lower level was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 94 and had a census of 80 at the time of this survey.	K 0000	The corrective action will be monitored by the Administrator or designee.	

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	All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 09/22/22			
K 0200 SS=D Bldg. 01	NFPA 101 Means of Egress Requirements - Other Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress 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. 18.2, 19.2 Based on observation and interview, the facility failed to ensure 3 of 3 egress doors from the large basement storage room/area, 1 of 47 resident room doors, and 1 of 1 Activities storage room, were not equipped with a latch or lock device on the outside of the door to ensure full instant use in the case of fire or other emergencies in accordance with LSC 7.1.10.1. This deficient practice could affect one resident in room 2 and staff while in the basement storage room/area and Activities storage room. Findings include: Based on observations on 09/14/22 between 1:15 p.m. and 4:00 p.m. during a tour of the facility with the Director of Maintenance and Administrator, the following was noted: a. There were three plywood doors to the basement storage room/area that had latches with locks on the corridor side of the room/area that could not be opened from inside this area	K 0200	The plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirement established by state and federal law. Attached for your review and approval, is the completed plan of correction for the recent Life and Safety Code Survey, Event ID 5IVX21, conducted on September 14, 2022 at Shadynook Care Center. Please be advised that it is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective October 3. 2022. Shadynook Care Center	10/03/2022

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	b. The C hall Activities storage room within the Nurses' Station room had a latch with a lock on the outside of the door that could not be opened from inside this room. c. Room 2 had a push button lock on the door with the push button side on the corridor side of the door which could not be unlocked and opened from inside the room. Based on interview at the time of each observation, the Director of Maintenance agreed these doors could not be unlocked from the inside while the latches and locks were in place. This finding was reviewed with the Director of Maintenance and Administrator during the exit conference. 3.1-19(b)		also respectfully requests a desk review for this plan of correction. K 0200 It is the policy of Shadynook Care Center to ensure that egress doors are equipped with a latch or lock devise on the door to ensure full instant use in the case of fire or another emergency. **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** No residents or staff were found to be affected due to alleged the deficient practice. Lock was immediately changed on room (2) door to ensure lock mechanism was on the inside of the door to ensure instant use. Three noted plywood doors to the basement storage room/area had doorknobs installed with latch/lock mechanism on the inside of the door to ensure instant use in event of emergency. The C Hall activities storage room within the nurse's station had lock removed to ensure instant use in the event of fire or emergency. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents or staff have the potential to be affected by the alleged deficient practice. The corrective action for this deficient practice included removal of	

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			latch/lock mechanisms and placed appropriately to comply with state and federal law, ensuring instant-use in the event of fire or emergency. All other doors were inspected to ensure compliance. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance will ensure that all doors have correct lock/latch mechanisms to maintain instant use in the event of fire or emergency. Maintenance or administrator will audit doors weekly X4 weeks then monthly X 6 months. All audits will be reviewed at QAPI for continued compliance. **How will the corrective action be monitored to ensure the deficient practice will not recur?** The corrective action will be monitored by the Maintenance Director or Administrator/designee.	
K 0211 SS=B 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			

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	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 1 corridor means of egress in the basement/lower level was continuously maintained free of obstructions. This deficient practice could affect staff only since residents do not go to the basement/lower level. Findings include: Based on observations on 09/14/22 between 1:15 p.m. and 4:00 p.m. during a tour of the facility with the Director of Maintenance and Administrator, there were five chairs stored in the basement/lower level egress corridor. Based on interview at the time of observation, when asked, the Director of Maintenance said the chairs had been there for several weeks. This finding was reviewed with the Director of Maintenance and Administrator during the exit conference. 3.1-19(b)	K 0211	The plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirement established by state and federal law. Attached for your review and approval, is the completed plan of correction for the recent Life and Safety Code Survey, Event ID 5IVX21, conducted on September 14, 2022 at Shadynook Care Center. Please be advised that it is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective October 3. 2022. Shadynook Care Center also respectfully requests a desk review for this plan of correction. K 0211 It is the policy of Shadynook Care Center to ensure that aisles, passageways, corridors, exit discharges, exit locations and accesses are maintained free of all obstructions to full use in case of emergency. **What corrective action will be accomplished for those residents found to be affected**	10/03/2022

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			by the deficient practice? No residents, staff or visitors were affected by the alleged deficient practice. All aisles, passageways, corridors, exit discharges, exit locations were audited to ensure no obstructions were present. Immediately X5 chairs stored in lower level/basement area were removed from area to ensure clearance of obstruction(s). **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents, staff or visitors have the potential to be affected by the alleged deficient practice. The corrective action for the deficient practice includes ensuring that all aisles, passageways, corridors, exit discharges and exit locations are clear and free of obstruction; immediately removing X5 chairs located in corridor of lower level/basement area. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The maintenance director will complete audit of all aisles, passageways, corridors, exit discharges and exit locations weekly ongoing to ensure compliance and areas are free of any obstruction(s). **How will the corrective action**	

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			be monitored to ensure the deficient practice will not recur? The corrective actions will be completed by the maintenance director or designee. Any areas of concern will be brought to the QA committee for review.	
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are 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			

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	space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies 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 3 of 3 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where	K 0222	The plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that the deficiency	10/14/2022

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	approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect up to 60 residents, as well as staff and visitors. Findings include: Based on observations on 09/14/22 between 1:15 p.m. and 4:00 p.m. during a tour of the facility with the Director of Maintenance and Administrator, all three exit doors equipped with a 15 second delayed egress were tested to ensure the irreversible process to release the magnetic lock on each door was working properly. These doors were located near the Supervisory Station between the D and C halls, the Dining Room, and the B hall exit door. The panic bars on these doors were pushed for over 3 seconds each and released. The door alarm did activate for each door but stopped when the panic bar was released. The doors did not release from the magnetic locks after 15 seconds. When the panic bars were pushed for over 15 seconds straight the doors did release from the magnetic locks and were able to be opened, furthermore, the doors did release from the magnetic lock when the code on the keypad was pressed. Based on interview at the time of each observation, the Director of		exists or that one was cited correctly. This plan of correction is submitted to meet requirement established by state and federal law. Attached for your review and approval, is the completed plan of correction for the recent Life and Safety Code Survey, Event ID 5IVX21, conducted on September 14, 2022 at Shadynook Care Center. Please be advised that it is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective October 3. 2022. Shadynook Care Center also respectfully requests a desk review for this plan of correction. K 0222 It is the policy of Shadynook Care Center to ensure that delayed egress locking arrangements are installed in accordance with state and federal law. What corrective action will be accomplished for those residents found to be affected by the deficient practice? No residents or staff were affected by the alleged deficient practice. A work order with Safecare is created to ensure the identified doors: the door near the supervisory station between D and C halls, the dining room door and the "B" hall exit door are all equipped with a delay of 15 seconds, as well as having an	

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	Maintenance agreed the previously mentioned exit doors were not operating as designed and need to ensure the irreversible process to release the magnetic lock on each door works properly. This finding was reviewed with the Director of Maintenance and Administrator during the exit conference. 3.1-19(b)		irreversible process. Ensuring the doors function properly and are in compliance with state and federal law. Dictation reviewed on the 2567 and noted on page 13 of 47 states, "the identified doors did release from the magnetic locks when the door code on the keypad was pressed." How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents and/or staff have the potential to be affected by the alleged deficient practice. A work order with Safecare is initiated for the (3) identified doors to ensure all mechanisms are functioning properly, that the identified doors are equipped with a delay of 15 seconds, as well as having an irreversible process. All other doors in facility were audited to ensure proper locking mechanisms were correct; meeting compliance in accordance with state and federal law. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance director or designee will audit all exit doors weekly for compliance.	

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			All negative findings will be immediately remedied and administrator will be notified. Findings will be brought to the safety committee meeting and monthly to QAPI. Administrator to monitor. How will the corrective action be monitored to ensure the deficient practice will not recur? The corrective action will be completed by the maintenance director or designee. The administrator will monitor corrective actions.	
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure 1 of 8 exit means of egress was properly lighted and would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect up to 61 residents as well as staff and visitors if required to exit through the dining room exit door in the event of an emergency. Findings include:	K 0281	The plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirement established by state and federal law. Attached for your review and approval, is the completed plan of correction for the recent Life and Safety Code Survey, Event ID	10/03/2022

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	Based on observations on 09/14/22 between 1:15 p.m. and 4:00 p.m. during a tour of the facility with the Director of Maintenance and Administrator, the dining room courtyard exit was provided with lighting directly outside the exit door under the porch overhang, however, there was no lighting provided beyond the porch overhang for the sidewalk that lead to the exit gate which was located around a corner of the building. Based on interview at the time of observation, the Director of Maintenance agreed there needs to be more exterior light provided within the courtyard. This finding was reviewed with the Director of Maintenance and Administrator during the exit conference. 3.1-19(b)		5IVX21, conducted on September 14, 2022 at Shadynook Care Center. Please be advised that it is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective October 3. 2022. Shadynook Care Center also respectfully requests a desk review for this plan of correction. E 0281 It is the policy of Shadynook Care Center that adequate illumination be provided to ensure enough light is provided for path of exit; emergency exits, in event of emergency. **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** No residents or staff were affected by the alleged deficient practice. After further review, a work order has been created to ensure installment of two flood lights allowing complete illumination and clear pathway in courtyard and described areas. Flood lights will be directly tied to emergency generator to ensure continued illumination following exit through egress. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?	

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			All residents and/or staff have the potential to be affected by the alleged deficient practice. Two flood lights wired to emergency generator to be installed to courtyard to ensure complete illumination and clear pathway exit in event of an emergency. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Flood lights will be directly tied to emergency generator system ensuring continued illumination and clear exit pathway through courtyard exit. How will the corrective action be monitored to ensure the deficient practice will not recur? This correction action and completion will be overseen by the administrator or maintenance director or designee. ="" p="">	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.			

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	19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to properly install exit signage within 1 of 1 courtyard in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect up to 61 residents, as well as staff and visitors in the dining room if needing to exit through the courtyard. Findings include: Based on observations on 09/14/22 between 1:15 p.m. and 4:00 p.m. during a tour of the facility with the Director of Maintenance and Administrator, there was a sidewalk leading to the courtyard gate, however, there was no directional exit sign provided which would lead residents and staff to the exit gate from the courtyard porch. The exit gate was located around the corner of the building and could not be seen from the courtyard porch. Based on interview at the time of observation, the Director of Maintenance agreed there was no directional exit sign in the courtyard to lead residents and staff to the exit gate. This finding was reviewed with the Director of Maintenance and Administrator during the exit conference.	K 0293	The plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirement established by state and federal law. Attached for your review and approval, is the completed plan of correction for the recent Life and Safety Code Survey, Event ID 5IVX21, conducted on September 14, 2022 at Shadynook Care Center. Please be advised that it is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective October 3. 2022. Shadynook Care Center also respectfully requests a desk review for this plan of correction. K 0293 It is the policy of Shadynook Care Center to ensure exit signage is properly installed for clarity of pathway in the event of an emergency. **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** No residents or staff were affected by the alleged deficient practice.	10/03/2022

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	3.1-19(b)		Please see attached emergency exit plan. Emergency illuminated exit signage was installed on gate directly in front of exit door to ensure clear pathway to emergency exit gate located in the courtyard. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents, staff and visitors have the potential to be affected by the alleged deficient practice. Emergency exit signage has been installed properly to facility's gate directly in front of emergency exit door to ensure clear designated pathway in the event of an emergency. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The maintenance director did complete audit of all emergency exits to ensure clarity of pathway is known in the event of an emergency. The maintenance director and administrator ensured proper installment of illuminated exit signage on gate located directly in front of emergency exit door according to facility's emergency exit plan. **How will the corrective action be monitored to ensure the deficient practice will not**	

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			recur? The corrective action will be completed and overseen by the Maintenance director or designee to ensure illuminated exit signage remains properly installed to facility's gate. Any areas of concern will be brought to the QA committee for review.	
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 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			

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	(exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	1. Based on observation and interview, the facility failed to ensure 1 of 1 egress corridor in the basement/lower level was not used to store combustible material. This deficient practice could affect mostly staff while in the basement/lower level, plus up to 20 residents from the C hall. Findings include: Based on observations on 09/14/22 between 1:15 p.m. and 4:00 p.m. during a tour of the facility with the Director of Maintenance and Administrator, the following was noted: a. The large storage area in basement was full of cardboard boxes, paper, plastic, old furniture, laundry supplies, and a variety of other storage items. This storage area was open to the corridor due to the wall that separates the storage area from the egress corridor only extending up about six feet from the floor to the top of the wall. The wall did not extend to the ceiling, but was open three or four feet to the ceiling across the entire storage area. b. There were at least 50 cardboard boxes full of clinical supplies stored on wood pallets in the area next to the basement/lower level exit door. Furthermore, this area would have to be traversed by residents and staff from the C hall to exit in the event the an emergency and unable to exit to the northeast end of the C hall. c. There was combustible storage and cleaning equipment stored at the northeast end of the basement/lower level within a small room only protected from the corridor by two metal grated	K 0321	The plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirement established by state and federal law. Attached for your review and approval, is the completed plan of correction for the recent Life and Safety Code Survey, Event ID 5IVX21, conducted on September 14, 2022 at Shadynook Care Center. Please be advised that it is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective October 3. 2022. Shadynook Care Center also respectfully requests a desk review for this plan of correction. K 0321 It is the policy of Shadynook Care Center to ensure that the egress corridor is in compliance with fire code and has an automatic fire extinguishing system in place. **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** No residents, staff or visitors were	10/03/2022

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	doors. These metal grated doors would not protect the egress corridor in the event of smoke or fire from this room. Based on interview at the time of observations, the Director of Maintenance said the previously mentioned items have been this way ever since he's been at the facility. This finding was reviewed with the Director of Maintenance and Administrator during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the corridor doors to 2 of over 10 hazardous area doors, such as an activity storage room door and maintenance room door, were provided with self closing devices. This deficient practice could affect at least 50 residents, staff, and visitors while in the dining room which was in the same smoke compartment as the Activity Room. Findings include: Based on observations on 09/14/22 between 1:15 p.m. and 4:00 p.m. during a tour of the facility with the Director of Maintenance and Administrator, the following was noted: a. The Activity Room was over 50 square feet in size, and full of combustible items such as cardboard boxes, paper, and plastic items plus other combustible storage items. The corridor door to this room was not provided with a self closing device to ensure the door would close automatically. b. The Maintenance Room in the basement/lower level was over 50 square feet in size, and full of combustible items such as cardboard boxes and		affected by the alleged deficient practice. A work order has been created to install a wired smoke detector by the housekeeping cage in the lower level/basement. Two wired smoke detectors to be installed in the lower level/basement. One wired smoke detector will replace a wired heat detector in place. Work order to be completed by 10 days. Door closures added to maintenance shop door and activity room door. All combustibles will be removed from the area next to the basement level exit door. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents, staff or visitors have the potential to be affected by the alleged deficient practice. The corrective action includes ensuring there is an automatic fire extinguishing system in place by installing x3 wired smoke detectors, door closures added to maintenance shop door and activity room door and all combustibles removed from the area next to the basement level exit door. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The maintenance director to	

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	maintenance equipment and supplies. The corridor door to this room was not provided with a self closing device to ensure the door would close automatically. Based on interview at the time of each observation, the Director of Maintenance agreed the doors to these two hazardous area rooms did not self close automatically when tested. This finding was reviewed with the Director of Maintenance and Administrator during the exit conference. 3.1-19(b)		ensure basement/lower level continues to meet requirements for an automatic fire extinguishing system in the corridors. Areas are separated from the other spaces by smoke resisting partitions. Ensure that all needed doors have door closures as required by state and federal law and all combustibles away from egress areas. **How will the corrective action be monitored to ensure the deficient practice will not recur?** The corrective actions and automatic fire extinguishing system will be monitored by the maintenance director or designee. All negative findings will be remedied immediately and administrator to be notified. Results will be brought to the monthly QAP meeting. Administrator to monitor.	
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 the cook tops in 1 of 1 Physical Therapy room was shut off at the switch when not in use. 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 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 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 at least 5 residents while in the Physical Therapy Room. Findings include:	K 0324	The plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirement established by state and federal law. Attached for your review and approval, is the completed plan of correction for the recent Life and Safety Code Survey, Event ID 5IVX21, conducted on September 14, 2022 at Shadynook Care Center. Please be advised that it is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective October 3. 2022. Shadynook Care Center also respectfully requests a desk review for this plan of correction. K0324 It is the policy of Shadynook Care Center to ensure cook tops are shut off at the switch when not in use.	10/03/2022

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	Based on observations on 09/14/22 between 1:15 p.m. and 4:00 p.m. during a tour of the facility with the Director of Maintenance and Administrator, there was a cooktop stove in the Physical Therapy room. The oven portion was full of several items including a tool box, plus paper and plastic items. The top of the stove had paper sitting on the burners. When asking about the stove and if it was turned off when not in use, Physical Therapy staff person #1 said the stove/oven was a mock stove that did not have power, it was only used for training purposes. When the front right burner was turned on, it did turn red and produce heat. This finding was reviewed with the Director of Maintenance and Administrator during the exit conference. 3.1-19(b)		**What corrective action will be accomplished for those residents found to be affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. The wire plug in mechanism for the stove to operate was immediately removed and a plate was added to cover any ability to utilize the operating plug. A face plate was added over the outlet ensuring the stove could not be functional in any capacity. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents, staff or visitors have the potential to be affected by the alleged deficient practice. The corrective action for this deficient practice included full removal of the plug, plate added covering the back of the stove and face plate covering applicable outlet added. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The maintenance director/designee will ensure that the stove located in the therapy gym remains fully non-operational. **How will the corrective action be monitored to ensure the deficient practice will not recur?**	

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			The corrective action will be monitored by the maintenance supervisor or designee. Any areas of concern will be brought to the QA committee for review.	
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ Based on observation and interview, the facility failed to ensure 1 of 1 egress corridor in the basement/lower level had a flame spread rating of Class A or Class B for a sprinklered facility. LSC 10.2.3.4 states products required to be tested in accordance with ASTM E 84, Standard Test Method for Surface Burning Characteristics of Building Materials, or ANSI/UL 723, Standard for Test for Surface Burning Characteristics of Building Materials, shall be classified as follows in accordance with their flame spread index and smoke developed index, except as indicated in 10.2.3.4(4): (1) Class A interior wall and ceiling finish shall be	K 0331	The plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirement established by state and federal law. Attached for your review and approval, is the completed plan of correction for the recent Life and Safety Code Survey, Event ID	10/03/2022

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	characterized by the following: (a) Flame spread index, 0-25 (b) Smoke developed index, 0-450 (2) Class B interior wall and ceiling finish shall be characterized by the following: (a) Flame spread index, 26-75 (b) Smoke developed index, 0-450 (3) Class C interior wall and ceiling finish shall be characterized by the following: (a) Flame spread index, 76-200 (b) Smoke developed index, 0-450 (4) Existing interior finish shall be exempt from the smoke developed index criteria of 10.2.3.4(1)(b), (2)(b), and (3)(b). This deficient practice could affect staff only since residents don't go to the basement/lower level. Findings include: Based on observations on 09/14/22 between 1:15 p.m. and 4:00 p.m. during a tour of the facility with the Director of Maintenance and Administrator, the corridor wall between the basement/lower level large storage room and egress corridor was only about six feet from the floor to the top of the wall, furthermore, the wall and the three doors within the length of the wall were all constructed of painted plywood with no flame spread rating. Based on interview at the time of observation, the Director of Maintenance said the plywood wall did not have a proper flame spread rating as far as he knew. This finding was reviewed with the Director of Maintenance and Administrator during the exit conference. 3.1-19(b)		5IVX21, conducted on September 14, 2022 at Shadynook Care Center. Please be advised that it is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective October 3. 2022. Shadynook Care Center also respectfully requests a desk review for this plan of correction. K 0331 It is the policy of Shadynook Care Center to ensure that interior wall and ceiling finishes, including exposed interior surfaces of the facility have a flame spread rating of Class A or Class B. **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. The corridor wall between the basement/lower-level large storage room and egress corridor that is described as painted plywood, has been replaced with a surface that has a flame spread rating of class A or class B per regulation. Smoke detectors to be added to the area to ensure a wired supervised smoke detection system is in place. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents, staff or visitors have	

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			the potential to be affected by the alleged deficient practice. A facility wide audit of smoke detectors was completed with all other areas noted to be in compliance. Wall surfaces that did not meet the class A or B rating have been replaced. Smoke detectors to be added to the noted area of non-compliance to ensure a supervised smoke detection system is in place. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The administrator or maintenance director/designee shall ensure that ensure that a wired smoke detector system is in place to meet compliance. Maintenance director was educated in reference to the requirement of a supervised smoke detector system as well as the flame spread rating for wall coverings. **How will the corrective action be monitored to ensure the deficient practice will not recur?** The corrective actions will be completed by the administrator or maintenance director or designee. Any areas of concern will be brought to the QA committee for review.	

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K 0341 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 2 fire alarm control annunciator panels was protected. NFPA 72, National Fire Alarm and Signaling Code Section 10.15 states in areas that are not continuously occupied, automatic smoke detection shall be provided at the location of each fire alarm control unit(s), notification appliance circuit power extenders, and supervising station transmitting equipment to provide notification of fire at that location. Exception: Where ambient conditions prohibit installation of automatic smoke detection, automatic heat detection shall be permitted. A.10.15 The fire alarm control unit(s) that are to be protected are those that provide notification of a fire to the occupants and responders. The term fire alarm control unit does not include equipment such as annunciators and addressable devices. Requiring smoke detection at the transmitting equipment is intended to increase the probability that an alarm signal will be transmitted to a	K 0341	The plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirement established by state and federal law. Attached for your review and approval, is the completed plan of correction for the recent Life and Safety Code Survey, Event ID 5IVX21, conducted on September 14, 2022 at Shadynook Care Center. Please be advised that it is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective October 3. 2022. Shadynook Care Center	10/03/2022

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	supervising station prior to that transmitting equipment being disabled due to the fire condition. CAUTION: The exception to 10.15 permits the use of a heat detector if ambient conditions are not suitable for smoke detection. It is important to also evaluate whether the area is suitable for the control unit. Where the area or room containing the control unit is provided with total smoke-detection coverage, additional smoke detection is not required to protect the control unit. Where total smoke-detection coverage is not provided, the Code intends that only one smoke detector is required at the control unit even when the area of the room would require more than one detector if installed according to the spacing rules in Chapter 17. The intent of selective coverage is to address the specific location of the equipment. Location of the required detection should be in accordance with one of the following: (1) Where the ceiling is 15 feet in height or less, the smoke detector should be located on the ceiling or the wall within 21 feet of the centerline of the fire alarm control unit being protected by the detector in accordance with 17.7.3.2.1. (2) Where the ceiling exceeds 15 feet in height, the automatic smoke detector should be installed on the wall above and within 6 feet from the top of the control unit. This deficient practice could affect all occupants. Findings include: Based on observations on 09/14/22 between 1:15 p.m. and 4:00 p.m. during a tour of the facility with the Director of Maintenance and Administrator, there was no hard wired smoke detector located in the area where the fire alarm annunciator panel was located on the wall across from the		also respectfully requests a desk review for this plan of correction. K 0341 It is the policy of Shadynook Care Center to ensure that the fire alarm control annunciator panels are protected. **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. A work order is submitted to install a smoke detector by the supervisor desk by one of two annunciator panels. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents, staff or visitors have the potential to be affected by the alleged deficient practice. The corrective action for this deficient practice includes installation of a wired smoke detector by the fire alarm annunciator panel. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The maintenance director or designee shall ensure that fire alarm annunciator panels are protected. **How will the corrective action be monitored to ensure the**	

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	Supervisory Station. Based on an interview at the time of observation, the Administrator said the Supervisory Station was not always occupied 24/7. She said staff would switch between the Supervisory Station and the C hall Nurses' Station. The Supervisory Station was unoccupied at the time of observation with the lights out. This finding was reviewed with the Director of Maintenance and Administrator during the exit conference. 3.1-19(b)		**deficient practice will not recur?** The corrective actions will be completed by the maintenance director or designee.All negative findings will be immediately remedied and Administrator to be notified. Findings will be brought to the safety committee meeting and monthly QAPI. Administrator to monitor.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. Based on record review and interview, the facility failed to ensure documentation for the sensitivity testing of 50 of 50 smoke detectors was complete. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of	K 0345	The plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirement established by state and federal law. Attached for your review and approval, is the completed plan of correction for the recent Life and	10/03/2022

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	detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 09/14/22 between 10:00 a.m. and 1:15 p.m. with the Director of Maintenance and Administrator present, the smoke detector sensitivity test report dated 02/25/21 was not a complete report. There was no alarm point for each smoke detector tested, only the work "Smoke" at the top of the column with a straight line through the rest of the column for each page. Based on interview at the time of record review, the Director of Maintenance confirmed there was no documentation available		Safety Code Survey, Event ID 5IVX21, conducted on September 14, 2022 at Shadynook Care Center. Please be advised that it is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective October 3. 2022. Shadynook Care Center also respectfully requests a desk review for this plan of correction. K 0345 It is the policy of Shadynook Care Center to ensure that smoke sensitivity test reports are completed accurately. **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. The electronic sensitivity report was obtained in reference to the dated report 2/23/21 indicating a complete report with no line drawn. (See attachment for reference) Electronic report does show documentation available to show the alarm point for each smoke detector tested for sensitivity. The most recent four quarterly fire alarm system inspection/testing reports dated 11/17/21 did not match reports dated 5/6/22 and 8/9/22 with a discrepancy of 13 smoke detectors (clarification facility has 49 not 50 smoke detectors) unsupervised. A vendor inspection	

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	to show the alarm point for each smoke detector tested for sensitivity during the 02/25/21 testing date. This finding was reviewed with the Director of Maintenance and Administrator during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure the documentation for the annual testing of all devices connected the fire alarm system was complete and accurate. NFPA 72, National Fire Alarm Code, the 2010 Edition, at 14.6.2.4 requires a record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 14.6.2.4: (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency (ies) (7) Designation of the detector(s) tested (8) Functional test of detectors (9)*Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Functional test of mass notification system control units (13) Functional test of signal transmission to mass		was immediately completed with complete walk through of facility, all smoke detectors to be overseen and supervised to meet compliance of state and federal law. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents, staff or visitors have the potential to be affected by the alleged deficient practice. The corrective action for the deficient practice includes accurate sensitivity electronic report from previous vendor. Ensuring facility inspection was immediately completed and all smoke detectors are supervised. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The maintenance director or designee shall ensure that it is complete and accurate, and all facility smoke detectors are supervised. **How will the corrective action be monitored to ensure the deficient practice will not recur?** The corrective actions will be completed by the maintenance director or designee.All negative findings will be immediately remedied and Administrator to be	

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	notification systems (14) Functional test of ability of mass notification system to silence fire alarm notification appliances (15) Tests of intelligibility of mass notification system speakers (16) Other tests as required by the equipment manufacturer's published instructions (17) Other tests as required by the authority having jurisdiction (18) Signatures of tester and approved authority representative (19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place). NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 09/14/22 between 10:00 a.m. and 1:15 p.m. with the Director of Maintenance and Administrator present, the most recent four quarterly fire alarm system inspection/testing reports dated 11/17/21, 02/22/22 (annual visual/functional inspection/test),		notified. Findings will be brought to the safety committee meeting and monthly QAPI.	

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	05/06/22, and 08/09/22 all indicated the facility was equipped with 36 electronically supervised smoke detectors. The most recent smoke detector sensitivity test dated 02/25/21 showed 50 electronically supervised smoke detectors in the facility. This was a discrepancy of 14 electronically supervised smoke detectors not visually inspected or functionally tested during the four quarterly/annual inspection/test. Based on interview, the Director of Maintenance said the sensitivity test was performed by a different fire alarm system vendor than the quarterly and annual inspections. When doing a side by side comparison of the reports, the Director of Maintenance said several of the smoke detectors not included on the quarterly and annual reports were located in closets and must have been missed by the correct vendor. This finding was reviewed with the Director of Maintenance and Administrator during the exit conference. 3.1-19(b)			
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete written policy for the	K 0346	The plan of correction constitutes the written allegation of	10/03/2022

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	protection of 80 of 80 residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants in the facility. Findings include: Based on record review on 9/14/22 between 10:00 a.m. and 1:15 p.m. with the Director of Maintenance and Administrator present, the facility provided fire watch documentation from the Emergency Preparedness plan, however, it was incomplete. The plan did include the phone number for the IDOH, however, the plan failed to include contacting the Indiana Department of Health (IDOH) with the web link for contacting the Incident Reporting System located on the IDOH Gateway, furthermore, the fire watch did not include documentation to indicate the person conducting the fire watch has been properly trained, and while conducting the fire watch that is the only duty/job to be performed. Based on an interview at the time of record review, the Director of Maintenance and Administrator confirmed the fire watch lacked the previously mentioned information. This finding was reviewed with the Director of Maintenance and Administrator during the exit conference. 3.1-19(b)		compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirement established by state and federal law. Attached for your review and approval, is the completed plan of correction for the recent Life and Safety Code Survey, Event ID 5IVX21, conducted on September 14, 2022 at Shadynook Care Center. Please be advised that it is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective October 3. 2022. Shadynook Care Center also respectfully requests a desk review for this plan of correction. K 0346 It is the policy of Shadynook Care Center to provide a complete written policy for the protection of residents, staff and visitors indicating procedures to be followed in the event of the fire alarm system being placed out of service for four hours or more in a twenty-four-hour period. **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. A policy/procedure was immediately revised to include the	

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			IDOH weblink for contacting the incident reporting system located on the IDOH gateway. The policy or procedure was also immediately revised to include indication of the person conducting the fire watch in that they are properly trained and that person has this as their designated sole responsibility during the fire watch. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents, staff or visitors have the potential to be affected by the alleged deficient practice. The corrective action for the deficient practice includes immediate revision of the facility fire watch policy to include the IDOH gateway weblink, ensuring proper training of the designated fire watch individual with documentation of the fire watch being the only duty/job to be performed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The administrator or maintenance director/designee shall ensure that ensure that all in-servicing/education is completed on or by September 30, 2022 of revisions to fire watch	

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			policy. **How will the corrective action be monitored to ensure the deficient practice will not recur?** The corrective actions will be completed by the administrator or maintenance director or designee. Maintenance Director or designee will perform random audits for compliance when fire watches are initiated.	
K 0353 SS=B Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure the ceiling in 2 of 6 sprinklered smoke compartments was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect 2 residents and staff.	K 0353	The plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that the deficiency	10/03/2022

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	Findings include: Based on observations on 09/14/22 between 1:15 p.m. and 4:00 p.m. during a tour of the facility with the Director of Maintenance and Administrator, the following was noted: a. 1 of 4 sprinkler escutcheons in the staff breakroom was missing leaving a half inch gap around the sprinkler pipe to the interstitial space between the basement/lower level and main level. b. 1 of 2 sprinkler escutcheons in resident room 20 was hanging one inch from the ceiling leaving a half inch gap around the sprinkler pipe to the attic. Based on interview at the time of each observation, the Director of Maintenance acknowledged the gaps around the sprinkler pipes in each of the previously mentioned locations. This finding was reviewed with the Director of Maintenance and Administrator during the exit conference. 3.1-19(b)		exists or that one was cited correctly. This plan of correction is submitted to meet requirement established by state and federal law. Attached for your review and approval, is the completed plan of correction for the recent Life and Safety Code Survey, Event ID 5IVX21, conducted on September 14, 2022 at Shadynook Care Center. Please be advised that it is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective October 3. 2022. Shadynook Care Center also respectfully requests a desk review for this plan of correction. K 0353 It is the policy of Shadynook Care Center that sprinklers are maintained in accordance with state and federal law. **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. Sprinkler escutcheons in staff break room were replaced to ensure no gap is around the sprinkler pipe to the interstitial space between the lower level and main level. The sprinkler escutcheon in resident room 20 was fixed to ensure it is not hanging and there is no gap around the sprinkler pipe to the attic.	

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			How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents, staff or visitors have the potential to be affected by the alleged deficient practice. The corrective action for the deficient practice includes replacing and fixing noted sprinklers in the staff break room and resident room 20 to comply with state and federal law. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Audit completed by maintenance director to ensure all sprinkler escutcheons are maintained in accordance with state and federal law. Audit to be completed by maintenance director/designee of all sprinkler escutcheons weekly X4 weeks, then monthly ongoing to ensure compliance. **How will the corrective action be monitored to ensure the deficient practice will not recur?** The corrective actions will be completed and overseen by the maintenance director or designee.	
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the			

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	extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)			
	Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed for the protection of 80 of 80 residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include:	K 0354	The plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirement established by state and federal law. Attached for your review and approval, is the completed plan of correction for the recent Life and Safety Code Survey, Event ID 5IVX21, conducted on September 14, 2022 at Shadynook Care Center. Please be advised that it is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective October 3. 2022. Shadynook Care Center also respectfully requests a desk review for this plan of correction. K 0354 It is the policy of Shadynook Care	10/03/2022

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	Based on record review on 9/14/22 between 10:00 a.m. and 1:15 p.m. with the Director of Maintenance and Administrator present, the facility provided fire watch documentation from the Emergency Preparedness plan, however, it was incomplete. The plan did include the phone number for the IDOH, however, the plan failed to include contacting the Indiana Department of Health (IDOH) with the web link for contacting the Incident Reporting System located on the IDOH Gateway, furthermore, the fire watch did not include documentation to indicate the person conducting the fire watch has been properly trained, and while conducting the fire watch that is the only duty/job to be performed. Based on an interview at the time of record review, the Director of Maintenance and Administrator confirmed the fire watch lacked the previously mentioned information. This finding was reviewed with the Director of Maintenance and Administrator during the exit conference. 3.1-19(b)		Center to ensure there is a complete written policy containing procedures to be followed in the event the automatic sprinkler system has been placed out-of-service for 10 hours or more in a twenty-four-hour period. **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. A policy/procedure was immediately revised to include the IDOH weblink for contacting the incident reporting system located on the IDOH gateway. The policy or procedure was also immediately revised to include indication of the person conducting the fire watch in that they are properly trained, and that person has this as their designated sole responsibility during the fire watch. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents, staff or visitors have the potential to be affected by the alleged deficient practice. The corrective action for the deficient practice includes immediate revision of the facility fire watch policy to include the IDOH gateway weblink, ensuring proper training of the designated fire	

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			watch individual with documentation of the fire watch being the only duty/job to be performed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The administrator or maintenance director/designee shall ensure that ensure that all in-servicing/education is completed on or by September 30, 2022 of revisions to fire watch policy. **How will the corrective action be monitored to ensure the deficient practice will not recur?** The corrective actions will be completed by the administrator or maintenance director or designee. Maintenance Director or designee will perform random audits for compliance when fire watches are initiated.	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility	K 0361	The plan of correction constitutes	10/03/2022

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	failed to ensure 2 of 2 areas in the basement/lower level open to the corridor were separated from the corridor by partitions capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect staff only since residents do not go to the basement/lower level. Findings include: Based on observations on 09/14/22 between 1:15 p.m. and 4:00 p.m. during a tour of the facility with the Director of Maintenance and Administrator, the following was noted: a. The staff breakroom was open to the corridor without direct supervision from a 24 hour station (i.e., Nurses' Station). b. The large storage room in the basement was open to the corridor without direct supervision from a 24 hour station (i.e., Nurses' Station). The wall between the large storage room and the egress corridor only extended up from the floor about 6 feet with an open area at the top 3 or 4 feet. Furthermore, LSC 19.3.6.1(7) was not met because the staff breakroom and the large storage room in the basement/lower level were not protected by an electrically supervised automatic smoke detection system. Based on interview at the time of each		the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirement established by state and federal law. Attached for your review and approval, is the completed plan of correction for the recent Life and Safety Code Survey, Event ID 5IVX21, conducted on September 14, 2022 at Shadynook Care Center. Please be advised that it is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective October 3. 2022. Shadynook Care Center also respectfully requests a desk review for this plan of correction. K 0361 It is the policy of Shadynook Care Center to ensure that all areas open to corridor spaces are protected by an electrically supervised automatic smoke detection system. **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. A work order was immediately initiated to ensure installation of an electrically supervised automatic smoke	

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	observation, the Director of Maintenance said residents do not come down into the basement/lower level and agreed these areas were not provided with electrically supervised automatic smoke detectors or a full wall or door to the egress corridor and was not directly supervised by a 24 hour station (i.e., Nurses' Station). This finding was reviewed with the Director of Maintenance and Administrator during the exit conference. 3.1-19(b)		detection system in the staff breakroom and the large storage room in the basement/lower level. Completion of wired smoke detector installation to be done within 10 days or less than 10 days of submission of plan of correction by vendor. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents, staff or visitors have the potential to be affected by the alleged deficient practice. The corrective action for the deficient practice includes ensuring electrically supervised automatic smoke detection systems are installed in the staff breakroom and large storage room in the basement/lower level. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The administrator and maintenance director will ensure installation of electrically supervised automatic smoke detection systems to staff breakroom and large storage room in basement/lower level. Maintenance Director was educated on the regulation regarding electrically supervised automatic smoke detection systems.	

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			How will the corrective action be monitored to ensure the deficient practice will not recur? The corrective actions will be completed by the administrator and maintenance director or designee. Any areas of concern will be brought to the QA committee for review.	
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 and interview, the facility failed to ensure 3 of over 20 wet locations, were provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel.	K 0511	The plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirement established by state and federal law. Attached for your review and approval, is the completed plan of correction for the recent Life and Safety Code Survey, Event ID 5IVX21, conducted on September 14, 2022 at Shadynook Care Center. Please be advised that it is our intent to have this plan of correction also serve as our	10/03/2022

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	(1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of		allegation of compliance. Compliance is effective October 3. 2022. Shadynook Care Center also respectfully requests a desk review for this plan of correction. K 0511 It is the policy of Shadynook Care Center that equipment using gas or related to gas piping complies with the national fuel gas code, electrical wiring and equipment complies with the national electric code. **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. A GFCI outlet was immediately installed to the electric receptacle in the activity office located near the sink. A GFCI outlet was immediately installed to the C Hall bathroom near the sink. A GFCI was immediately installed to the electric receptacle in the beauty salon near the sink. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents, staff or visitors have the potential to be affected by the alleged deficient practice. The corrective action for the deficient practice includes installation of guard-fault circuit interrupter	

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	the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect at least 2 residents and staff. Findings include: Based on observations on 09/14/22 between 1:15 p.m. and 4:00 p.m. during a tour of the facility with the Director of Maintenance and Administrator, the following was noted: a. The electric receptacle in the Activity Office was within two feet of the sink and was not provided with a GFCI protected receptacle. When tested with a GFCI testing device, it did not break the electrical circuit. b. The C Hall bathroom had one electric receptacle within two feet of the sink that was provided with a GFCI protected receptacle, however, when tested with a GFCI testing device, the electric circuit was not broken. The testing device showed the receptacle to be wired Hot/Neutral Reverse. c. The electric receptacle in the Salon was within four feet of the counter sink and was not provided with a GFCI protected receptacle. When tested with a GFCI testing device, it did not break the electrical circuit. Based on interview at the time of each observation, the Director of Maintenance agreed the previously mentioned receptacles were not GFCI protected. This finding was reviewed with the Director of Maintenance and Administrator during the exit conference. 3.1-19(b)		outlets to the activity office, C Hall bathroom and beauty salon. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The maintenance director did a complete audit of all wet locations to ensure they were provided with ground fault circuit interrupter protection against electric shock. GFCI outlets to be audited by the maintenance director or designee on continued monthly basis to ensure compliance. **How will the corrective action be monitored to ensure the deficient practice will not recur?** The corrective actions will be completed by the maintenance director or designee. Any areas of concern will be brought to the QA committee for review.	

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K 0521 SS=C Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on observation and interview, the facility failed to ensure egress corridors were not used as a portion of a return air system serving adjoining rooms for 47 of 47 resident rooms and 5 of 5 egress corridors. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, Section 4.3.12.1.1 states egress corridors in nursing and long term care facilities shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas unless otherwise permitted by 4.3.12.1.3.1 through 4.3.12.1.3.4. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on observations on 09/14/22 between 1:15 p.m. and 4:00 p.m. during a tour with the Director of Maintenance and Administrator, all 47 resident rooms were using the egress corridors as a return air system. Based on interview at the time of the observations, the Administrator stated the facility has an existing Life Safety Code waiver for all 47 resident sleeping rooms and agreed the egress corridors were being used for the return air system. This finding was reviewed with the Director of Maintenance and Administrator during the exit	K 0521	Please see attached Life & safety waiver request form. The facility has been granted a waiver for K021 each year since 1990, when the tag was first cited. Following the 1990 survey, the facility had installed a system whereby the activation of the fire alarm, including the automatic sprinkler system and the automatic smoke detection would shut down the supply air fans. In 1990, the facility obtained an estimate from a contractor to install return air ducts in each residents room. The cost at that time was approximately $29,782.00. All fire protection devices tested by Safe Care on an annual basis. Sprinkler system tested by Safe Care quarterly. Facility maintenance conducts fire drills quarterly on shifts (1) and (2) when alarm is tripped.	09/15/2022

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	conference. 3.1-19(b)			
K 0541 SS=E Bldg. 01	NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chu Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 1. Based on observation and interview, the facility failed to maintain 1 of 1 laundry chute door to be fully self-closing and positive latching. LSC 9.5.2 requires trash chutes shall be installed and maintained per NFPA 82, 2009 Edition. NFPA 82 5.2.3.3.1.1 requires all chute loading doors into a	K 0541	The plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that the deficiency	10/03/2022

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	trash chute shall be provided with a self-closing, positive latching frame and gasketed door assembly. This deficient practice could affect over 10 residents, as well as staff and visitors. Findings include: Based on observation on 09/14/22 between 1:15 p.m. and 4:00 p.m. during a tour of the facility with the Director of Maintenance and Administrator, the main level laundry chute door was not fully self-closing and would not close completely and latch into its frame. When the chute door was opened fully it would stay in that position. When tested further, the door could not be pushed closed completely. There was a one inch gap between the door and its frame. Based on interview at the time of observation, the Director of Maintenance agreed the laundry chute door did not operate as designed. This finding was reviewed with the Director of Maintenance and Administrator during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 soiled linen chute was provided with automatic extinguishing protection in accordance with LSC 9.7. LSC Section 9.7 states each automatic sprinkler system required by another section of this code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 Edition, Section 21.15.2.2.1.1 states gravity chutes shall be protected internally by automatic sprinklers unless they are lined in accordance with Section 5.2.2.6.1 in NFPA 82, Standard on		exists or that one was cited correctly. This plan of correction is submitted to meet requirement established by state and federal law. Attached for your review and approval, is the completed plan of correction for the recent Life and Safety Code Survey, Event ID 5IVX21, conducted on September 14, 2022 at Shadynook Care Center. Please be advised that it is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective October 3. 2022. Shadynook Care Center also respectfully requests a desk review for this plan of correction. K 0541 It is the policy of Shadynook Care Center to ensure that the laundry chute/linen system is provided with automatic fire extinguishing protection. **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. The facility ensured that the laundry chute door operates effectively; ensuring that it self-closes, has a positive latch and is a gasketed door. A work order was immediately created to have a sprinkler installed to meet compliance of state and federal law. **How other residents have the**	

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	Incinerators and Waste and Linen Handling Systems and Equipment, 2009 Edition. This protection requires that a sprinkler be installed at or above the top service opening of the chute. Automatic sprinklers installed in gravity chute service openings shall be recessed out of the chute area through which the material travels. In addition, a sprinkler shall be installed within the chute at alternate floor levels in buildings over two stories in height, with a mandatory sprinkler located at the lowest service level. This deficient practice could affect 1 or more staff in the vicinity of the soiled linen chute on the main level, plus any residents in the vicinity of the soiled linen room. Findings include: Based on observations on 09/14/22 between 1:15 p.m. and 4:00 p.m. during a tour of the facility with the Director of Maintenance and Administrator, the soiled linen chute between the main level and basement/lower level was not equipped with an automatic sprinkler in the chute. Based on interview at the time of the observation, the Director of Maintenance agreed an automatic sprinkler could not be located within the soiled linen chute. This finding was reviewed with the Director of Maintenance and Administrator during the exit conference. 3.1-19(b)		**potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents, staff or visitors have the potential to be affected by the alleged deficient practice. The corrective action for the deficient practice includes that the linen system/laundry system operates with a self-closing, positive latch gasketed door and that a sprinkler is installed to meet compliance of state and federal law. Instillation of sprinkler at the laundry chute/linen system. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The maintenance director to complete an audit of the laundry chute door to ensure that it has a self-closing, positive latch gasketed door weekly X4 weeks then monthly to ensure compliance. The maintenance director to ensure the sprinkler installed remains in place and working condition to meet compliance. **How will the corrective action be monitored to ensure the deficient practice will not recur?** The corrective actions will be completed by the maintenance director or designee. Any areas of concern will be brought to the QA	

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			committee for review.	
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide a complete facility specific written fire safety plan for the protection of 80 of 80 residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear	K 0711	The plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirement established by state and federal law. Attached for your review and approval, is the completed plan of correction for the recent Life and Safety Code Survey, Event ID 5IVX21, conducted on September 14, 2022 at Shadynook Care Center. Please be advised that it is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective October 3.	10/03/2022

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	width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the facility's "Fire Procedures" on 09/14/22 between 10:00 a.m. and 1:15 p.m. with the Director of Maintenance and Administrator present, the plan did not address the following items: a. A back up call to 9-1-1 after the fire alarm has been activated b. Staff response to battery powered smoke alarms located in resident sleeping rooms. c. The use of the K-class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead extinguishing system. d. The removal of wheeled equipment from the corridor in the event of an emergency. Furthermore, it was stated at "4. Fire in Operational Areas, A. Kitchen: d. Evaluate severity to determine if automatic stove extinguisher is required (may result in greater damage and clean-up.)" Based on interview at the time of record review, the Director of Maintenance acknowledged and agreed that the fire safety plan did not address the previously mentioned items and the #4 statement concerning the automatic stove extinguishment		2022. Shadynook Care Center also respectfully requests a desk review for this plan of correction. K 0711 It is the policy of Shadynook Care Center to ensure that there is an evacuation written plan for all residents, staff and visitors for their evacuation in the event of an emergency. **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. The facility ensured that the emergency evacuation plan was revised to include verbiage stating that a backup call to 9-1-1 be placed after the fire alarm has been activated. Plan and policy revision to include staff response to battery powered smoke alarms located in resident sleeping rooms. Plan and policy revision to include the use of the K-class fire extinguisher in the kitchen in relationship with the use of the overhead extinguishing system. Plan and policy revision to include the removal of wheeled equipment from the corridor in the event of an emergency. Plan and policy revision to remove “determination of severity level if stove extinguisher is required as this may result in greater damage and clean-up.” Plan and policy to add use of stove extinguisher	

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	155525	A. BUILDING 01 B. WING	09/14/2022

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	should either be corrected or removed. This finding was reviewed with the Director of Maintenance and Administrator during the exit conference. 3.1-19(b)		immediately. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents, staff or visitors have the potential to be affected by the alleged deficient practice. The corrective action for the deficient practice includes evacuation plan and policy revision to ensure calling 9-1-1 as back up once alarm activation has occurred, staff response to battery powered smoke alarms located in resident sleeping rooms, K-class extinguisher use, removal of wheeled equipment from corridors and removal of verbiage from evacuation plan “determination of level of severity” associated with stove extinguisher. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The administrator ensured that staff were educated on the revised evacuation plan/procedure before or on September 30, 2022. (Attachment B) All new employees will undergo training during general orientation which will include the language of the revised evacuation plan. All staff to maintain ongoing education according to policy of facility. **How will the corrective action**	

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			be monitored to ensure the deficient practice will not recur? The corrective actions will be completed by the administrator or maintenance director or designee. Any areas of concern will be brought to the QA committee for review.	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 3 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 09/14/22 between 10:00 a.m. and 1:15 p.m. with the Director of Maintenance and Administrator present, three of four, second shift (evening) fire drills were performed between 6:20 p.m. and 6:35 p.m. Based on interview at the time of record review, the Director of Maintenance and	K 0712	The plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirement established by state and federal law. Attached for your review and approval, is the completed plan of correction for the recent Life and Safety Code Survey, Event ID 5IVX21, conducted on September	10/03/2022

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	Administrator acknowledged the times of the second shift fire drills were performed and agreed the times were not varied enough. This finding was reviewed with the Director of Maintenance and Administrator during the exit conference. 3.1-19(b)		14, 2022 at Shadynook Care Center. Please be advised that it is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective October 3. 2022. Shadynook Care Center also respectfully requests a desk review for this plan of correction. K 0712 It is the policy of Shadynook Care Center to ensure that fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. To ensure fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. Quarterly fire drills to be completed at varied times. Staff will remain familiar with procedures and are aware that drills are part of the facility established routine, however, drills will be tailored to not be expected at same time frame in order to simulate an emergency. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents, staff or visitors have	

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			the potential to be affected by the alleged deficient practice. The corrective action for the deficient practice includes ensuring that all quarterly fire drills are scheduled to be varied in time to ensure simulation of emergency. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The administrator or designee will complete audit of all quarterly fire drills to ensure time has variance to simulate emergency, in that staff will not be expectant of "timed" drill but rather only expectant of fire drills being a part of facility established routine. **How will the corrective action be monitored to ensure the deficient practice will not recur?** The corrective actions will be completed by the administrator or designee. Any areas of concern will be brought to the QA committee for review.	