STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155657	A. BUILDING -- B. WING	12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR CORYDON, IN 47112

(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: 12/12/23 Facility Number: 010597 Provider Number: 155657 AIM Number: 200204440 At this Emergency Preparedness survey, Harrison Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 92 certified beds and had a census of 79 at the time of this visit. Quality Review completed on 12/18/23	E 0000	**Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law.** **The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey conducted on December 12, 2023. Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **Brandon Jensen, LNHA**	
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: 12/12/23 Facility Number: 010597 Provider Number: 155657	K 0000	**Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandon Jensen	ED	12/28/2023

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

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	AIM Number: 200204440 At this Life Safety Code survey, Harrison Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 92 and had a census of 79 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. The facility has one detached storage building which was not sprinklered. Quality Review completed on 12/18/23		**required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey conducted on December 12, 2023. Please accept this plan of correction as the provider's credible allegation of compliance. The facility would like to respectfully request a desk review. Brandon Jensen, LNHA**	
K 0222 SS=D 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			

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	permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall			

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	be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 13 delayed egress locks were readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6. (b) The doors unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds.	K 0222	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** No residents were harmed by the alleged deficient practice. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Door was adjusted and delayed egress was observed in working order. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The ED/Designee held an in-service with facility maintenance director on K-222 as it relates to delayed egress doors and the facility process for monitoring of delayed egress. **STEP 4 Corrective actions to be monitored to ensure the**	01/16/2024

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	The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect over 2 staff and visitors if needing to exit the kitchen to the outside of the facility. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:25 p.m. on 12/12/23, the exit door to the outside of the facility in the kitchen was marked as a facility exit with an exit sign. The door was marked as a delayed egress door with the necessary delayed egress signage but the door did not release to open after pushing for 15 seconds when tested to open multiple times. The exit door also had a keypad at the exit door to release the door to open but the code to release the door to open was not posted. The Maintenance Director entered a code into the keypad which released the door to open. Based on interview at the time of the observations, the Maintenance Director stated the exit door was a delayed egress door as well and agreed the exit door would not release to open after pushing for 15 seconds when tested to open multiple times.		**deficient practice will not recur:** The Maintenance Director /Designee will audit 3 delayed egress doors a week x 4 weeks, then 2 delayed egress doors a week x 4 weeks, then 1 delayed egress door a week x 4 weeks for no less than 3 months and compliance is maintained to ensure delayed egress is in working order. The Maintenance Director/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation and interview, the facility failed to meet the clear width requirement for 1 of 7 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire	K 0232	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** No residents were harmed by the alleged deficient practice. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Table was removed from corridor. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The ED/Designee held an in-service with facility maintenance director on K-232 as it relates to clear width requirements.	01/16/2024

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	protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8. This deficient practice could affect over 10 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:25 p.m. on 12/12/23, a wooden table which was not affixed to the floor or to the wall was stored in the corridor outside the Sprinkler Control Valve/Maintenance office and projected two feet into the eight foot wide corridor. The measurements were made using a measuring tape. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned furniture storage location was not affixed to the floor or to the wall. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		**STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The Maintenance Director /Designee will perform facility rounds 3 days a week x 4 weeks, then 2 days a week x 4 weeks, then weekly x 4 weeks for no less than 3 months and compliance is maintained to ensure clear width requirements are met in all corridors. The Maintenance Director/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance			

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	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 observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility at 2:28 p.m. on 12/12/23, the display for the "Node 1" fire alarm control panel in the Electrical Room near the center nurse's station was in the trouble mode. The display for the panel read "Battery Charge Capacity" as the cause of the fire alarm system trouble. The main fire alarm control panel near the Sprinkler Control Valve/Maintenance office was also in the trouble mode. Based on interview at the time of the observations, the Maintenance Director stated he just received a text message from the off-site fire alarm system monitoring company at 1:39 p.m. on 12/12/23 indicating the system trouble for the "Battery Charge Capacity" issue commenced at	K 0345	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** No residents were harmed by the alleged deficient practice. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Battery was replaced, system date and time updated, and control panel was observed to be operational with no trouble mode displayed. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The ED/Designee held an in-service with facility maintenance director on K-345 as it relates to maintenance of fire alarm system and accurate date and time information. **STEP 4 Corrective actions to be monitored to ensure the**	01/16/2024

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	that date and time and showed the text message on his cell phone to the surveyor. Based on interview at the time of the observations, the Maintenance Director stated he did not yet have time to look into correcting the issue because he was participating in the Life Safety Code survey being conducted, the battery charging issue would not affect whether or not the fire alarm system could be activated and agreed the fire alarm system for the facility was currently in the trouble mode. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the fire alarm system to ensure that it had accurate time and date information in accordance with the requirements of NFPA 101, 2012 edition, Sections 19.3.4 and 9.6 and NFPA 72, 2010 edition, Sections 14.1 and 14.1.1. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:25 p.m. on 12/12/23, the main fire alarm system control panel located near the Sprinkler Control Valve/Maintenance office read the time of day as 2:53 p.m. at 1:23 p.m. Based on interview at the time of the observations, the Maintenance Director agreed the main fire alarm system control panel displayed the incorrect time of day.		**deficient practice will not recur:** The Maintenance Director /Designee will observe fire system 3 days a week x 4 weeks, then 2 days a week x 4 weeks, then weekly x 4 weeks for no less than 3 months and compliance is maintained to ensure system is operational, not in trouble mode, and displays accurate date and time information. The Maintenance Director/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review, observation and interview; the facility failed to ensure 1 of 1 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2011 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Table 7.1.1.2 requires wet and dry barrel hydrants to be inspected annually and after each operation. This deficient practice could affect all residents, staff and visitors. Findings include:	K 0353	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** No residents were harmed by the alleged deficient practice. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** City was contacted to ensure fire hydrant is maintained by the city.	01/16/2024

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	Based on record review with the Executive Director and the Maintenance Director from 10:50 a.m. to 1:10 p.m. on 12/12/23, annual private fire hydrant inspection documentation for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated the facility has at least one fire hydrant which the city fire department inspects and tests regularly but does not provide the inspection and testing documentation to the facility. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:25 p.m. on 12/12/23, one fire hydrant was noted outside the building near the emergency generator for the facility on the northwest side of the property. Based on interview at the time of the observations, the Maintenance Director agreed annual inspection documentation for the fire hydrant within the most recent twelve month period was not available for review. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 kitchens. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected		**STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The ED/Designee held an in-service with facility maintenance director on K-353 as it relates to maintenance of fire hydrants. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The Maintenance Director /Designee will audit all fire hydrants monthly to insure they are maintained by the city. The Maintenance Director/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	based on the type of sprinkler and the type of construction. This deficient practice could affect over two staff and visitors in the kitchen. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:25 p.m. on 12/12/23, an irregular shaped ceiling tile in the kitchen in between the kitchen range hood system and the kitchen wall was not correctly positioned in the ceiling tile grid which exposed the interstitial space above the tile and the grid. The ceiling tile was irregularly cut and shaped in order to allow it to be positioned up against components of the wall mounted kitchen range hood fire suppression system. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned ceiling tile was not correctly positioned within the ceiling tile grid which would delay activation of the sprinklers installed in the kitchen. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0355 SS=D Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 24 portable fire extinguishers	K 0355	**STEP 1 Corrective action for the residents found to have**	01/16/2024

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	were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect over two staff in the Laundry. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:25 p.m. on 12/12/23, the affixed maintenance tag for the ABC type portable fire extinguisher located in the Laundry indicated annual maintenance for the fire extinguisher was performed by the contractor in February 2023 but lacked a monthly inspection for November 2023. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned portable fire extinguisher location had missing monthly inspection documentation for November 2023.		**been affected by the deficient practice:** No residents were harmed by the alleged deficient practice. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Fire extinguisher was inspected with no concerns noted. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The ED/Designee held an in-service with facility maintenance director on K-355 as it relates to monthly fire extinguisher inspections. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The Maintenance Director /Designee will observe 5 fire extinguishers week x 4 weeks, then 3 fire extinguishers a week x 4 weeks, then 1 fire extinguisher x 4 weeks for no less than 3 months and compliance is maintained to ensure monthly inspections have been timely documented. The Maintenance Director/Designee will present the results of these audits monthly to the QAPI committee for no less	

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	These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3,			

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	unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 4 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:25 p.m. on 12/12/23, the following was noted: a. the opening for the latching plate on the door frame for the corridor door to the Environmental Services Support room was taped over which would not allow the latching mechanism on the door to protrude into the latching plate on the door frame. b. hangers for personal protection equipment were hung over the top of the corridor door to resident sleeping Room 104 and to resident sleeping Room 302 which did not allow each door to latch into the door frame when tested to close multiple times. c. a wedge was placed on the floor under the corridor door to Room 109 to prop the door in the fully open position. Based on interview at the time of the	K 0363	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** No residents were harmed by the alleged deficient practice. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Tape was removed from corridor door to Environmental Services Support room and door was observed in working order. Hangers were removed from doors of resident rooms 104 and 302 and doors observed in working order. Wedge was removed from door of room 109 and door was observed in working order. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The ED/Designee held an in-service with facility staff on	01/16/2024

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	observations, the Maintenance Director agreed the aforementioned corridor doors each had an impediment to closing and latching into the door frame, would not resist the passage of smoke and removed the tape on the door frame for the corridor door to the Environmental Services Support room. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		K-363 as it relates to insuring there no impediment to closing and latching of corridor doors. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The Maintenance Director /Designee will observe 5 corridor doors week x 4 weeks, then 3 corridor doors a week x 4 weeks, then 1 corridor door x 4 weeks for no less than 3 months and compliance is maintained to ensure no impediment to closing or latching. The Maintenance Director/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.			

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	18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure electrical wiring in 1 of 1 kitchens was maintained in safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 300.15 states a box or conduit body shall be installed at each junction point unless otherwise permitted by 300.15(A) through (I). Article 314.28 states boxes and conduit bodies used as pull or junction boxes shall comply with 314.28 (A) through (E). This deficient practice could affect over 2 staff and visitors in the kitchen. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:25 p.m. on 12/12/23, exposed spliced electrical wiring was noted above an irregular shaped ceiling tile in the kitchen which was not correctly positioned in the ceiling tile grid in between the kitchen range hood system and the kitchen wall. The incorrectly positioned ceiling tile exposed the interstitial space and the spliced electrical wiring. The spliced electrical wiring was not contained within a junction box or conduit body. Based on interview at the time of the observations, the Maintenance Supervisor agreed the exposed electrical wiring was not contained within a junction box or conduit body. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)	K 0511	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** No residents were harmed by the alleged deficient practice. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Safecare was contacted by Maintenance Director and repairs scheduled. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The ED/Designee held an in-service with facility maintenance director on K-511 as it relates to proper containment of electrical wires. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The Maintenance Director /Designee will perform facility rounds 3 days a week x 4 weeks, then 2 days a week x 4 weeks, then weekly x 4 weeks for no less than 3 months and compliance is maintained to ensure proper containment of electrical wires. The Maintenance	01/16/2024

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			Director/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
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 conduct quarterly fire drills under varying conditions on the first and second shifts for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drills" documentation with the Executive Director and the Maintenance Director during record review from 10:50 a.m. to 1:10 p.m. on 12/12/23, three of four first shift fire drills conducted within the most recent twelve	K 0712	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** No residents were harmed by the alleged deficient practice. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Random fire drill was conducted on first and second shift.	01/16/2024

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	month period on 12/28/22, 06/04/23 and 09/27/23 were conducted at, respectively, 9:00 a.m., 9:15 a.m. and 10:00 a.m. In addition, three of four second shift fire drills conducted within the most recent twelve month period on 02/23/23, 08/31/23 and 11/03/23 were conducted at, respectively, 6:00 p.m., 7:00 p.m. and 6:00 p.m. Based on interview at the time of record review, the Maintenance Director stated the facility plans ahead of time to conduct fire drills at varied times and stated some of the fire drills were events where the fire alarm system was activated unexpectedly for whatever reason at which time they would go ahead and use that occurrence as a documented fire drill but agreed the aforementioned first and second shift fire drills were not conducted at unexpected times under varying conditions. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) and 3.1-51(c)		**STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The ED/Designee held an in-service with facility maintenance director on K-712 as it relates to conducting fire drills at unexpected times under varying conditions **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The Maintenance Director/Designee will audit monthly fire drills to insure they were conducted at unexpected times under varying conditions. The Maintenance Director/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
K 0741 SS=D Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following			

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	provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on record review, observation and interview; the facility failed to provide a smoking policy for a facility allowing staff smoking. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Executive Director and the Maintenance Director from 10:50 a.m. to 1:10 p.m. on 12/12/23, a smoking policy for a facility allowing staff smoking was not available for review. Based on interview at the time of	K 0741	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** No residents were harmed by the alleged deficient practice. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Facility staff smoking policy was created.	01/16/2024

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	record review, the Executive Director stated the facility is a non-smoking facility. Based on observations with the Executive Director and the Maintenance Director at 1:47 p.m. on 12/12/23, multiple staff members were observed smoking on the property outside the kitchen. Based on interview at the time of the observations, the Executive Director agreed a smoking policy for a facility allowing staff smoking was not available for review. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		**STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The ED/Designee held an in-service with facility staff on expectations as it relates to staff smoking policy. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The Maintenance Director /Designee will perform facility rounds 3 days a week x 4 weeks, then 2 days a week x 4 weeks, then weekly x 4 weeks for no less than 3 months and compliance is maintained to ensure staff in adherence with staff smoking policy. The Maintenance Director/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met:			

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	o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6			
	Based on observation and interview, the facility failed to ensure 1 of over 50 corridor doors was maintained in accordance with 19.7.5.6. 19.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area	K 0753	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** No residents were harmed by the alleged deficient practice. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Decorative holiday plastic sheeting was removed from Environmental Service Director office door. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The ED/Designee held an in-service with the Maintenance and Environmental Service directors on K-753 as it relates to decorations on corridor doors.	01/16/2024

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	limitations of 19.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. (5)*They are decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Environmental Services Director's office. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:25 p.m. on 12/12/23, decorative holiday plastic sheeting was affixed to the corridor door to the Environmental Services Director's office and covered over 70% of face of the corridor side of the door. The plastic sheeting did not have affixed documentation indicating the material was fire retardant or fire retardant treated. Based on interview at the time of the observations, the Maintenance Director stated he was not aware if the affixed plastic		**STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The Maintenance Director /Designee will perform facility rounds 3 days a week x 4 weeks, then 2 days a week x 4 weeks, then weekly x 4 weeks for no less than 3 months and compliance is maintained to ensure no combustible decoration are present on corridor doors. The Maintenance Director/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	sheeting had been treated with fire retardant material and agreed fire resistance rating documentation for the plastic sheeting was not available for review. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility	K 0920	**STEP 1 Corrective action for**	01/16/2024

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	155657	A. BUILDING 01 B. WING	12/12/2023

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	failed to ensure 2 of 2 extension cords including power strips and multiplug adaptors were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over twenty residents, staff and visitors in the vicinity of resident sleeping Room 107. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:25 p.m. on 12/12/23, a cell phone charging cable and Christmas tree lighting was plugged into a power		**the residents found to have been affected by the deficient practice:** No residents were harmed by the alleged deficient practice. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Power strip, multiplug adaptor, and extension cord was removed room 107. Resident was educated on life safety code as it relates to use of power strips, multiplug adaptors, and extension cords. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The ED/Designee held an in-service with facility staff on K-920 as it relates to use of power strips, multi plug adaptors, and extension cords. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The Maintenance Director /Designee will observe 5 resident rooms week x 4 weeks, then 3 resident rooms a week x 4 weeks, then 1 resident room x 4 weeks for no less than 3 months and compliance is maintained to ensure no extension cords including unapproved power strips	

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	strip laying on top of a refrigerator stored within six feet of the resident bed nearest the window in resident sleeping Room 107. The UL listing of the power strip could not be determined. In addition, an operating fan and a coffee pot were plugged into a multiplug adaptor which was plugged into an extension cord behind the refrigerator. Based on interview at the time of the observations, the Maintenance Director agreed power strips, extension cords and multiplug adaptors were being used in the patient care vicinity for non-PCREE and as a substitute for fixed wiring at the aforementioned location in the facility. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		and multi plug adaptors are being used as a substitute for fixed wiring. The Maintenance Director/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.			

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	Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 2 of 25 cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 1 indoor oxygen storage areas. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.1 states storage for nonflammable gases equal to or greater than 85 cubic meters (3000 cubic feet) shall comply with 5.1.3.3.2 and 5.1.3.3.3. NFPA 99, Section 5.1.3.3.2(7) requires cylinders be provided with racks, chains, or other fastenings to secure all cylinders from falling, whether connected, unconnected, full or empty. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room near Room 313.	K 0923	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** No residents were harmed by the alleged deficient practice. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Oxygen cylinders were placed into proper cylinder stand. **STEP 3 Measures/systemic changes put into place to**	01/16/2024

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	Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:25 p.m. on 12/12/23, two of twenty five 'E' type oxygen cylinders stored in the oxygen storage and transfilling room by Room 313 were laying on top of oxygen cylinders stored in a floor mounted rack and were not properly chained or supported in a proper cylinder stand or cart. A total of 13 liquid oxygen containers and 25 'E' type oxygen cylinders were stored in the room. Based on interview at the time of the observations, the Executive Director and the Maintenance Director agreed two of the twenty five oxygen cylinders in the oxygen storage and transfilling room by Room 313 were not properly chained or supported in a proper cylinder stand or cart. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		**ensure the deficient practice does not recur:** The ED/Designee held an in-service with the Maintenance director and direct care staff on K-923 as it relates to proper storage of oxygen cylinders. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The Maintenance Director /Designee will perform facility rounds of oxygen storage rooms 3 days a week x 4 weeks, then 2 days a week x 4 weeks, then weekly x 4 weeks for no less than 3 months and compliance is maintained to ensure proper storage of oxygen cylinders. The Maintenance Director/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	