STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155070	A. BUILDING -- B. WING	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREEN VALLEY CARE CENTER	3118 GREEN VALLEY RD NEW ALBANY, IN 47150

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/19/23 Facility Number: 000028 Provider Number: 155070 AIM Number: 100275370 At this Emergency Preparedness survey, Green Valley Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 141 certified beds, with a current census of 121. Quality Review completed on 10/31/23	E 0000		
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: 10/19/23 Facility Number: 000028 Provider Number: 155070 AIM Number: 100275370 At this Life Safety Code survey, Green Valley Care Center was found not in compliance with	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Greg Dattilo	Executive Director	12/05/2023

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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	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 was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery powered smoke alarms in all resident sleeping rooms. The facility has a capacity of 141 and had a census of 121 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 10/31/23			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 1. Based on observation and interview, the facility failed to ensure corridor doors to 2 of over 75 rooms would close and latch into the door frame per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 20 residents, staff, and visitors.	K 0100	K100 – General Requirements **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Maintenance Director fixed doors	11/18/2023

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	Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, the corridor door to the Medical Records room and the old mail room each located near the conference room near the main entrance lobby were both equipped with a self-closing device, but each door would not self-close and latch into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned corridor door locations did not self-close and latch into the door frame when tested to close multiple times. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review, observation, and interview; the facility failed to ensure two of over four corridor doors sets were maintained per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 20 residents, staff, and visitors. Findings include: Based on review of "Swing Door Inspection" documentation dated 08/30/23 with the Administrator and the Maintenance Director during record review from 9:20 a.m. to 11:55 a.m. on 10/19/23, two door label locations are painted. The aforementioned documentation stated the		so they self-close and latch in the following locations Medical Records Office Old Mail Room Maintenance Director removed paint so the Fire Resistance Rating were visible at the following locations 9A by room 521 13A by the Sensor Room **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** 20 Resident, Staff, and Visitors could be affected. No residents were affected. Maintenance Director and Maintenance assistant have been educated that doors need to be self-closing and that fire ratings on doors need to be legible and not painted over. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director and Maintenance assistant have been educated that doors need to be self-closing and that fire ratings on doors need to be legible and not painted over. **How will the corrective actions be monitored to ensure the**	

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	labels for the doors identified as "9A by 521" and "13A by Sensor Room" were "Painted Over". Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, the fire resistance rating labels on the aforementioned two door locations were painted and not legible. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		**deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Maintenance Director/Designee to complete auditing of all doors to ensure that all doors self-close and latch and that fire ratings are visible and legible on corridor doors. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 13 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of	K 0211	K211 – Mean of Egress **What corrective actions will be accomplished for those residents found to have been**	11/18/2023

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	fire or other emergency. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, a wooden stair device for the Therapy Gym was stored in the corridor outside Room 602 in the 600 Hall. The device projected three feet into the eight foot wide corridor. An upholstered chair was also stored in the corridor outside Room 603 in the 600 Hall and also projected three feet into the eight foot wide corridor. Based on interview at the time of the observations, the Maintenance Director stated the 600 Hall does not currently house any residents and has been vacant for an unspecified period of time but agreed the aforementioned means of egress was not continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		**affected by the deficient practice?** Maintenance Director immediately moved Wooden Stairs from corridor in 600 Hall **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Over 20 residents, staff, and visitors could be affected by Means of Egress being free from obstructions Maintenance Director audited all corridors for anything that would obstruct any means of Egress. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director and Maintenance assistant have been educated on Means of Egress **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Maintenance Director/Designee to complete auditing of all Corridors are free from obstructions. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months.	

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			The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are 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			

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	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 be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	1. Based on observation and interview, the facility failed to ensure the means of egress through 2 of 2 delayed egress locks were readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1,	K 0222	K222 – Egress Doors **What corrective actions will be accomplished for those residents found to have been**	11/18/2023

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	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. 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 20		**affected by the deficient practice?** Maintenance Director immediately fixed door so that Codes listed matched up with the code that marked in the following locations Exit on 300 hall next to room 316 Exit in the Sunroom Maintenance Director fixed corridor door set to the kitchen from the service hall so that it had more than one releasing operation. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Over 20 residents, staff, and visitors could be affected by Door codes not matching the codes that were marked. Over 2 Kitchen have the potential of being affected Maintenance Director and Maintenance assistant have been educated on Egress Doors. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director and Maintenance assistant have been educated on Egress Doors. **How will the corrective actions be monitored to ensure the**	

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	residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, the exit door to the outside of the facility in the Sun Room and the exit door to the outside of the facility in the 300 Hall by Room 316 were each marked as a facility exit with an exit sign. Each exit door also had a keypad at the exit door to release the door to open. The code to release each door to open was posted at the exit door but it was the incorrect code to release the door to open. Each door was not marked as a delayed egress door with the necessary delayed egress signage. Each door was a delayed egress door as the door released to open after pushing for 15 seconds. Based on interview at the time of the observations, the Maintenance Director stated each exit door was a delayed egress door as well and agreed the doors were not posted with the necessary delayed egress signage. 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 provide 1 of 1 corridor door sets to the kitchen from the service hall with not more than one releasing operation. LSC Section 7.2.1.5.10 states a latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and readily operated under all lighting conditions. The		**deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Maintenance Director/Designee to complete auditing of all Egress doors. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	

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	releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches above the finished floor. Doors shall be operable with not more than one releasing operation. Section A.7.2.1.5.10 states examples of devices that might be arranged to release latches include knobs, levers, and panic bars. This deficient practice could affect over 2 kitchen staff. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, the corridor door set to the kitchen from the service hall was equipped with two locks on the door. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned door set required more than one releasing operation to open the door. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0223 SS=E Bldg. 01	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect			

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	smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure 1 of 1 sets of smoke barrier doors in the 600 Hall are self-closing and kept in the closed position, unless held open by a release device complying with LSC Section 7.2.1.8.2. This deficient practice could affect over 20 residents, staff and visitors in the 600 Hall. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, the north door identified as door 4A in the corridor door set in the 600 Hall was propped in the fully open position with a paint can placed up against the door. Based on interview at the time of the observations, the Maintenance Director stated the 600 Hall does not currently house any residents and has been vacant for an unspecified period of time but agreed a paint can was used to prop the north door in the corridor door set in the fully open position. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)	K 0223	K223 – Doors with Self-Closing Devices **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Maintenance Director immediately removed Paint Can so it would not prop open door with Self-Closing Device. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Over 20 residents could be affected by having objects propping open doors with self-closing devices. Maintenance Director audited all doors with self-closing devices. Maintenance Director and Maintenance assistant have been educated on Doors with self-closing devices **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director and Maintenance assistant have been	11/18/2023

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			educated on Doors with self-closing devices **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Maintenance Director/Designee to complete auditing of all doors with self-closing devices to make to ensure they are free of any objects propping open door. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	
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	K 0232	K232 – Aisle, Corridor, or Ramp Width	11/18/2023

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(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
	13 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 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 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, an upholstered chair was		**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Maintenance Director immediately removed upholstered chair from Corridor. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Over 20 residents, staff, and visitors have the potential to be affected. Maintenance Director audited all corridors to ensure there was nothing violating the 3 foot rule for an 8 foot Corridor. Maintenance Director and Maintenance assistant have been educated on items not projecting more than 3 feet in an 8 foot corridor. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director and Maintenance assistant have been educated on items not projecting more than 3 feet in an 8 foot corridor. **How will the corrective actions be monitored to ensure the**	

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	155070	A. BUILDING 01 B. WING	10/19/2023

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	stored in the corridor outside Room 603 in the 600 Hall and projected three feet into the eight foot wide corridor. The chair was not affixed to the floor or to the wall. Based on interview at the time of the observations, the Maintenance Director stated the 600 Hall does not currently house any residents and has been vacant for an unspecified period of time but agreed the aforementioned furniture storage location was not affixed to the floor or to the wall. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		**deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Maintenance Director/Designee to complete auditing of all Corridors to ensure there nothing projecting more than 3 feet in an 8 foot Corridor. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	
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 egress lighting for 2 of 14 exit means of egress was arranged so the failure of any single lighting fixture (bulb) 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	K 0281	K281 – Illumination of Means of Egress **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The outdoor lighting fixtures for Exits from 600 Hall and Therapy	11/18/2023

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	could affect over 20 residents, staff and visitors in the facility if needing to exit the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, the exit discharge for the 600 Hall by Room 619 was equipped with two separate light bulbs but one of the two light bulbs was burnt out. In addition, the exit discharge for the Therapy Room was equipped with only one lighting fixture containing a single light bulb. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned two exit discharges was not equipped with the minimum number of operable lighting fixtures. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		were completely replaced with new outdoor lighting fixtures **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Over 20 residents, staff, and visitors have the potential to be affected. Maintenance Director audited all outdoor lighting fixtures to ensure that they fixtures are working properly. Maintenance Director and Maintenance assistant have been educated on Illuminations of Means of Egress **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director and Maintenance assistant have been educated on Illuminations of Means of Egress **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Maintenance Director/Designee to complete auditing of all outdoor lighting fixtures to ensure they are working properly. Auditing will	

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			occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 2 of over 15 battery powered emergency lighting systems was maintained in accordance with LSC Section 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70, National Electric Code. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, the battery operated lighting system affixed to the wall above the exit door to the outside of the facility in the 300 Hall	K 0291	K291 – Emergency Lighting **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Emergency Lighting fixtures for both 300 and 600 were replaced. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Over 20 residents, staff, and visitors have the potential to be affected. Maintenance Director audited all Emergency Exit Fixtures to ensure they are working properly	11/18/2023

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	by Room 319 and in the 600 Hall by Room 619 each failed to illuminate when its respective test button was pushed multiple times. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned battery powered emergency lighting systems failed to illuminate when its respective test button was pushed multiple times. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		Maintenance Director and Maintenance assistant have been educated on proper working Emergency Lighting **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director and Maintenance assistant have been educated on proper working Emergency Lighting **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Maintenance Director/Designee to complete auditing of all Emergency Lighting Fixtures to ensure all are working properly. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	

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K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to replace battery operated smoke alarms installed in all resident sleeping rooms in the 600 Hall in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.2.1.1.1 states inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the 600 Hall. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, manufacturer's documentation affixed to the BRK Model 83R battery operated smoke detector mounted on the ceiling in resident sleeping room 608. 609, 614, 616 and 617 in the 600 Hall each indicated the smoke detector was manufactured in June 2000. Room 618 did not have a smoke detector installed in the resident sleeping room. Based on interview at the	K 0300	K300 – Protection **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Smoke Detectors in rooms 608, 609, 614, 616, 617 will be replaced with new Smoke Detectors Smoke Detector will be installed in room 618 **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Over 20 residents, staff, and visitors have the potential to be affected. Maintenance Director audited all Smoke Detectors to ensure they were less than 10 years old and all rooms had Smoke Detectors. Maintenance Director and Maintenance assistant have been educated on Smoke Detectors to ensure they are less than 10 years old and that all rooms had a	11/18/2023

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	time of the observations, the Maintenance Director stated the 600 Hall does not currently house any residents and has been vacant for an unspecified period of time. The Maintenance Director stated battery operated smoke detectors installed in other portions of the facility were replaced in 2022 but the 600 Hall battery operated smoke detectors were not replaced at that time and agreed resident sleeping room battery operated smoke detectors installed in the 600 Hall were each was more than ten years old. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		Smoke Detector installed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director and Maintenance assistant have been educated on Smoke Detectors to ensure they are less than 10 years old and that all rooms had a Smoke Detector installed.	
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			

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	Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 3 of over 11 hazardous areas such as combustible storage rooms/spaces (over 50 square feet) and soiled linen and trash collection rooms exceeding 64 gallons were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, the following was noted: a. the corridor door to the Clean Utility Room in the 600 Hall had a hole in the door where a door handle had been installed which caused the door to not latch into the door frame. Two large trash bags each filled with clothes exceeding 64 gallons were stored in the room. b. the self closing device on one of the corridor doors in the door set to the kitchen storage room from the service corridor was removed. The kitchen storage room exceeded fifty square feet in size and was used to store combustible boxes for	K 0321	K321 – Hazardous Area - Enclosure **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Maintenance Director placed door knob in door that had hole Maintenance Director installed Self-Closing Device in kitchen Maintenance Director fixed Self-Closing Device door for room 611 **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Over 20 residents, staff, and visitors have the potential to be affected. Maintenance Director audited all doors that require Self-Closing Devices to ensure they worked properly and were present on	11/18/2023

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	kitchen supplies. c. the self closing device for the corridor door to Room 611 failed to self close and latch the door into the door frame when tested to close multiple times. Room 611 exceeded fifty square feet in size and was used to store combustible boxes and supplies. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned three hazardous areas were not separated from other spaces with smoke resistant partitions and doors. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		those said doors. Maintenance Director and Maintenance assistant have been educated on Hazardous Area – Enclosures. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director and Maintenance assistant have been educated on Hazardous Area – Enclosures. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Maintenance Director/Designee to complete auditing of all hazardous Areas-Enclosure to ensure Self-closing Devices to ensure they were working properly and installed. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	

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K 0324 SS=D 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 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 1. Based on record review, observation, and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon	K 0324	K324 – Cooking Facilities **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Maintenance Director scheduled kitchen exhaust inspection for December 2023 Maintenance Director fixed door to kitchen so that it would have more than one releasing operation to open door. **How other residents have the**	11/18/2023

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	inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect all kitchen staff. Findings include: Based on review of the kitchen range hood inspection contractor's "Service Report" documentation dated 06/12/23 with the Executive Director and the Maintenance Director during record review from 10:20 a.m. to 1:30 p.m. on 10/19/23, documentation of a kitchen exhaust system inspection six months prior to 06/12/23 was not available for review. Based on interview at the time of record review, the Maintenance Director agreed documentation of a kitchen exhaust system inspection six months prior to 06/12/23 was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, the kitchen range hood inspection contractor had affixed a sticker to the kitchen range hood which only documented the most recent kitchen range hood inspection		**potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All Kitchen staff have the potential to be affected. Maintenance Director audited all inspections for the kitchen to ensure they have been completed as required and that all corridor doors have more than one releasing operation. Maintenance Director and Maintenance assistant have been educated on Kitchen Facilities. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director and Maintenance assistant have been educated on Kitchen Facilities. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Maintenance Director/Designee to complete auditing of all kitchen inspections and door sets that require more than one releasing operation. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3	

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	conducted on 06/12/23. 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 provide 1 of 1 corridor door sets to the kitchen from the service hall with not more than one releasing operation. LSC Section 7.2.1.5.10 states a latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches above the finished floor. Doors shall be operable with not more than one releasing operation. Section A.7.2.1.5.10 states examples of devices that might be arranged to release latches include knobs, levers, and panic bars. This deficient practice could affect over 2 kitchen staff. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, the corridor door set to the kitchen from the service hall was equipped with two locks on the door. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned door set required more than one releasing operation to open the door. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference.		months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	

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(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
	3.1-19(b)			
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 maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 2010 Edition. Section 10.5.5.2.1 states, the location of the dedicated branch circuit disconnecting means shall be permanently identified at the control unit. Section 10.5.5.2.2 states, for fire alarm systems the circuit disconnecting means shall be identified as "FIRE ALARM CIRCUIT." Section 10.5.5.2.3 states for fire alarm systems the circuit disconnecting means shall have a red marking. Section 10.5.5.2.4 states the circuit disconnecting means shall be accessible only to authorized personnel. Section 10.5.5.3 states the dedicated branch circuit(s) and connections shall be protected against physical damage. This deficient practice could affect all residents, staff and visitors.	K 0341	K341 – Fire Alarm System - Installation **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Alarm Circuit Breaker now has red signage that identifies as “Alarm Circuit Breaker” and has a locked placed on breaker box **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents, staff, and visitors have the potential to be affected.	11/18/2023

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	155070	A. BUILDING 01 B. WING	10/19/2023

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	Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, the fire alarm circuit breaker in the wall mounted electrical panel in the basement identified as "Panel E ATS 2 Gen Power" was not identified with red marking as "fire alarm circuit" and access to the circuit breaker was not locked. Based on interview at the time of the observations, the Maintenance Director agreed the dedicated branch circuit disconnecting means for the facility's fire alarm system was not properly identified and was not locked. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		Maintenance Director has audited all breaker boxes to ensure proper identification and are locked properly Maintenance Director and Maintenance assistant have been educated on fire alarm systems the circuit disconnecting means shall be identified as "FIRE ALARM CIRCUIT." Section 10.5.5.2.3 states for fire alarm systems the circuit disconnecting means shall have a red marking. Section 10.5.5.2.4 states the circuit disconnecting means shall be accessible only to authorized personnel. Section 10.5.5.3 states the dedicated branch circuit(s) and connections shall be protected against physical damage. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director and Maintenance assistant have been educated on fire alarm systems the circuit disconnecting means shall be identified as "FIRE ALARM CIRCUIT." Section 10.5.5.2.3 states for fire alarm systems the circuit disconnecting means shall have a red marking. Section 10.5.5.2.4 states the circuit disconnecting means shall be accessible only to authorized personnel. Section 10.5.5.3 states the dedicated branch circuit(s) and connections shall be protected	

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			against physical damage. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Maintenance Director/Designee to complete auditing fire alarm systems the circuit disconnecting means shall be identified as "FIRE ALARM CIRCUIT." Section 10.5.5.2.3 states for fire alarm systems the circuit disconnecting means shall have a red marking. Section 10.5.5.2.4 states the circuit disconnecting means shall be accessible only to authorized personnel. Section 10.5.5.3 states the dedicated branch circuit(s) and connections shall be protected against physical damage. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	
K 0351 SS=E	NFPA 101 Sprinkler System - Installation			

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Bldg. 01	Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) 1. Based on observation and interview, the facility failed to maintain the ceiling construction for 1 of 2 ceilings in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, the following ceiling mounted sprinkler locations were each missing its escutcheon:	K 0351	K351– Sprinkler System – Installation **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Escutcheons will be installed on the following Sprinkler Heads Kitchen 600 Hall Utility Room 600 Hall Shower Room Room 615 Room 620 400 Hall Sensory Room Sprinklers will be installed for the holes in the Conference Room	11/18/2023

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	a. in the kitchen. b. 600 Hall Clean Utility Room. c. 600 Hall Shower Room. d. in the restroom for Room 615. e. in Room 620. f. in the closet in the Sensory Room. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned ceiling mounted sprinkler locations were each missing its escutcheon. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, 2010 Edition, Section 8.5.1.1 states sprinklers shall be located, spaced, and positioned in accordance with the requirements of Section 8.5. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the conference room near the main entrance lobby. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, a bulkhead extended down more than 18 inches from the ceiling above the eraser board area of the conference room near the main entrance lobby. The bulkhead created obstruction to the sprinkler spray pattern for the ceiling mounted sprinklers installed in the room.		**How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** 20 residents, staff, and visitors have the potential to be affected. Maintenance Director Audited all Sprinkler Heads to ensure Escutcheons are installed and installed properly Maintenance Director and Maintenance assistant have been educated on plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. Maintenance Director and Maintenance assistant have been educated on states sprinklers shall be located, spaced, and positioned **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director and Maintenance assistant have been educated on PIVs and holes in the ceiling. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Maintenance Director/Designee to	

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	The area above the eraser board was not equipped with sprinklers. Based on interview at the time of the observations, the Maintenance Director agreed the area behind the bulkhead above the eraser board area in the conference room was not provided with sprinkler coverage. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 3.1-19(ff)		complete auditing all Sprinkler heads to ensure all Sprinkler heads are installed and installed properly. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	
K 0352 SS=F Bldg. 01	NFPA 101 Sprinkler System - Supervisory Signals Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 Based on observation and interview, the facility failed to maintain automatic sprinkler systems in accordance with LSC 9.7. LSC 19.3.5.1 states buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. LSC 9.7.2.1 states where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National	K 0352	Waiver has been requested K352 – Sprinkler System – Supervisory Signals **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** PIV will have Electronically Monitor System installed	01/31/2024

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	Fire Alarm and Signaling Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, the Post Indicator Valve (PIV) located outside the facility on the southeast side of the property was not electrically supervised. Based on interview at the time of the observations, the Maintenance Director agreed the PIV was not electrically supervised. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		**How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents, staff, and visitors have the potential to be affected. Maintenance Director has call facility monitoring service to get PIV Monitoring System installed Maintenance Director and Maintenance assistant have been educated on PIVs **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director and Maintenance assistant have been educated on PIVs **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Maintenance Director/Designee to complete auditing of PIV to ensure Monitoring System is working properly. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews	

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			will be increased as needed if any areas of noncompliance are identified during the auditing process.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility did not ensure 1 of 1 fire department connections was in accordance with NFPA 25, 2011 Edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 13.7.1 requires fire department connections to be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition.	K 0353	K353– Sprinkler System – Maintenance and Testing **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** PIV Identification Sign mounted Sprinklers will be installed for the holes in the Conference Room Ceiling holes in the basement have been fixed **How other residents have the**	11/18/2023

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	(5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, the fire department connection (FDC), which was located next to the Post Indicator Valve (PIV) outside the facility on the southeast side of the property, was not provided with an identification sign. Based on interview at the time of the observations, the Maintenance Director agreed the FDC was not provided with the necessary identification signage. 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 on 2 of 2 levels in the facility in accordance with NFPA 13. 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 based on the type		**potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** 10 residents, staff, and visitors have the potential to be affected. Maintenance Director ensued there were no holes in the ceiling Maintenance Director and Maintenance assistant have been educated on PIVs and holes in the ceiling. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director and Maintenance assistant have been educated on PIVs and holes in the ceiling. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Maintenance Director/Designee to complete auditing of PIV to ensure of proper signage and holes in ceiling. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews	

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	of sprinkler and the type of construction. This deficient practice could affect over 10 residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, two holes were noted in the suspended ceiling behind the bulkhead above the eraser board in the conference room near the main entrance lobby. In addition, a ten inch long hole was noted in the ceiling in the basement corridor outside the sprinkler riser room entrance door. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned openings did not maintain the ceiling construction in the two ceiling smoke barriers. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of over 100 sprinkler heads in the facility were replaced in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage		will be increased as needed if any areas of noncompliance are identified during the auditing process.	

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	(2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect over 2 staff and visitors in the kitchen. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, the sprinkler installed on the ceiling in the Janitor's Closet in the kitchen was green with corrosion. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned automatic sprinkler location was corroded. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 4. Based on observation and interview, the facility failed to maintain all sprinkler systems in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 edition, Section 5.2.2.2 states sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect over two staff			

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	and visitors in the basement Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, one white data cable was affixed to horizontal sprinkler piping near the ceiling in the Maintenance Shop in the basement. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned sprinkler pipe location was used to support non-system components. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 4 of 45 portable fire extinguishers 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	K 0355	K355 – Portable Fire Extinguishers **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Fire Extinguishers in the following location were inspected and marked inspected for the following locations Therapy Gym	11/18/2023

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	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 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, the affixed maintenance tag for the following ABC type portable fire extinguisher locations in the facility did not document a monthly inspection for the following monthly periods: a. Therapy Gym for August and September 2023. b. Activities Room for July, August and September 2023. c. in the service corridor outside the storage room for July, August and September 2023. d. in the kitchen by the MSDS room for September 2023. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned portable fire extinguisher locations each had missing monthly inspection documentation. These findings were not reviewed with the Executive Director and the Maintenance Director during the exit conference.		Activity Room Service Hall Corridor Kitchen MSDS room **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** 20 residents, staff, and visitors have the potential to be affected. Maintenance Director ensured all Fire Extinguishers were inspected and marked inspected. Maintenance Director and Maintenance assistant have been educated that Fire Extinguishers are inspected and properly marked. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director and Maintenance assistant have been educated that Fire Extinguishers are inspected and properly marked. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Maintenance Director/Designee to complete auditing of all Fire Extinguishers to ensure they have been inspected and marked	

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	3.1-19(b)		inspected. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	
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			

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	applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 6 of over 100 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 40 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, the following was noted: a. a two inch in diameter hole was noted in the corridor door to the 300 Hall Assistant Director of Nursing Office. b. the corridor door to the service hall was not equipped with a positive latching device. c. the corridor door to Room 424 would not latch into the door frame when tested to close multiple times.	K 0363	K363 – Corridors - Doors **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The following areas were fixed Corridor to ADON Office Containers were removed making it a non-storage area Room 424 latches into door frame **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** 40 residents, staff, and visitors have the potential to be affected. Maintenance Director ensured	11/18/2023

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	d. a wedge was placed under the corridor door to Room 603 to prop the door in the fully open position. e. the corridor door to the 600 Hall Clean Utility room was not provided with a door handle to latch the door into the door frame. f. the corridor door the the offices behind the 600 Hall Nurse's Station Office was not provided with a door handle to latch the door into the door frame. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned corridor doors had an impediment to closing and latching into the door frame and would not resist the passage of smoke. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		Corridors are free of holes that they latch properly to door frames and that proper latches are installed. Maintenance Director and Maintenance assistant have been educated that Corridors corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director and Maintenance assistant have been educated that Corridors corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Maintenance Director/Designee to complete auditing of all Corridor Doors to ensure doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months. The results of these reviews will be	

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			discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	
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. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure wall mounted electrical outlet boxes in 1 of 1 Environmental Supply Closets in the 300 Hall was protected. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. Article 406.5, states receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect over 2 staff and visitors in the 300 Hall Environmental Supply Closet. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, the wall mounted outlet box nearest the floor in the 300 Hall Environmental	K 0511	K511– Utilities – Gas and Electric **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** 300 Hall Supply Closet wall mounted outlet box was replaced with new cover **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** 2 residents, staff, and visitors have the potential to be affected. Maintenance Director ensured all outlet covers were covered and free of cracks Maintenance Director and	11/18/2023

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	Supply Closet was missing its cover plate. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned outlet box was not completely covered with a cover plate. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		Maintenance assistant have been educated that receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director and Maintenance assistant have been educated that receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Maintenance Director/Designee to complete auditing of all Electrical Outlets to ensure receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months.	

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			Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	
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, observation and interview; the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. 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	K 0711	K711 Evacuation and relocation Plan **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Policy and Procedure placed in the Emergency Preparedness Binder **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective**	11/18/2023

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	evacuation (9) Extinguishment of fire Section 19.2.3.4(4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 inches. (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness Manual: Facility Fire" documentation dated 07/18/23 and "If You Discover a Fire" documentation with the Administrator and the Maintenance Director during record review from 9:20 a.m. to 11:55 a.m. on 10/19/23, the written fire safety plan did not address the relocation of wheeled equipment during a fire or similar emergency. Based on interview at the time of record review, the Executive Director agreed the written fire safety plan did not address the relocation of wheeled equipment during a fire or similar emergency. Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, Hoyer lifts were stored in the corridor up against the wall outside Room 502, 513, 514 and Room 609. A wheelchair not in use was stored in the corridor		**actions will be taken?** 0 residents, staff, and visitors were affected. Executive Director ensured all Policy and Procedure were placed in the Emergency Preparedness Binder All staff assistant have been educated on relocation of wheeled equipment during a fire or similar emergency. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All staff have been educated on relocation of wheeled equipment during a fire or similar emergency. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Executive Director/Designee to complete auditing of Emergency Preparedness Binder to ensure p/p for relocation of wheeled equipment during a fire or similar emergency. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews	

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	outside Room 603. Wheeled blood pressure cuff devices were stored in the corridor and plugged into wall mounted outlet boxes outside Room 206 and Room 316. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		will be increased as needed if any areas of noncompliance are identified during the auditing process.	
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: 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 1 Activities Director's Office 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	K 0753	K753 Combustible Decorations **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Plastic Sheeting was removed from Activity Room door **How other residents have the**	11/18/2023

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	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 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 5 residents, staff and visitors in the vicinity of the		**potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** 5 residents, staff, and visitors have the potential to be affected. Maintenance Director audited all doors to ensure there no plastic sheeting or any other material that is not approved to be on the resident and staff doors. Maintenance Director and Maintenance assistant have been educated on combustible decorations shall be prohibited in any health care occupancy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director and Maintenance assistant have been educated on combustible decorations shall be prohibited in any health care occupancy. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Executive Director/Designee to complete auditing of all resident and staff office door to ensure there is no combustible decorations on resident and staff office doors. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's	

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	Activities Director's Office. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, plastic sheeting was affixed to the corridor door to the Activities Director's Office and covered the entire 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 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)		monthly x's 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are			

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	permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility failed to ensure unattended trash receptacles in 1 of 1 service halls were stored in a room protected as a hazardous area in accordance with Section 19.7.5.7. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the service hall. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, one unattended partially filled 55 gallon capacity trash cart and one unattended partially filled 96 gallon capacity recycling cart were stored near one another in the service hall by the employee time clock. The combined capacity of the carts exceeded 32 gallons. The service hall was open to the corridor as the corridor door to the service hall was not equipped with a positive latching device to latch the door into the door frame. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned receptacles were not being stored in a room protected as a hazardous area when unattended. These findings were reviewed with the Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b)	K 0754	K754 Soiled Linen and Trash Containers **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** 55 gallon capacity trash cart and 96 gallon recycling cart were removed from the Service Hallway. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** 10 residents, staff, and visitors have the potential to be affected. Maintenance Director audited ensured all containers 32 Gallons or more were stored in the proper areas. Maintenance Director and Maintenance assistant have been educated on unattended trash receptacles are stored in a room protected as a hazardous area in accordance with Section 19.7.5.7. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director and	11/18/2023

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(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
			Maintenance assistant have been educated on unattended trash receptacles are stored in a room protected as a hazardous area in accordance with Section 19.7.5.7. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Executive Director/Designee to complete auditing of all unattended trash receptacles are stored in a room protected as a hazardous areas. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life			

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	155070	A. BUILDING 01 B. WING	10/19/2023

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	safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on observation and interview, the facility failed to ensure 1 of 2 emergency generators was installed in accordance with the provisions of NFPA 110. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Section 7.2.1 states the Emergency Power Supply (EPS) shall be installed in a separate room for Level 1 installations or be located in an adequate enclosure located outside the building capable of resisting the entrance of snow or rain at a maximum wind velocity required by local building codes. Section 7.2.1.2 states no other equipment,	K 0918	Waiver has been requested K918 – Electrical Systems – Essential Electrical System **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Nameplate for Generator 1 did contain manufactured date Generator Doors have signage to identify	01/31/2024

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	including architectural appurtenances, except that service this space, shall be permitted in this room. Section 7.7.1 states with the EPS running at rated load, ventilation air flow shall be provided to limit the maximum air temperature in the EPS room to the maximum ambient air temperature required by the EPS manufacturer. Section 7.7.2.1 states ventilation air shall be supplied directly from a source outside the building by an exterior wall opening or from a source outside the building by a 2-hour fire rated air transfer system. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, one of two emergency generators for the facility is located inside the building and is accessed from the laundry room. The emergency generator is identified as Generator #1 and is propane fired. The affixed manufacturer's nameplate rating for the generator was 40 kW but the manufacture date could not be determined. Access to the generator room from the laundry is through an unlabeled set of double doors. Neither door was self-closing, and each door had an open louver installed in the bottom of the door. Two separate louvers were installed in the outside wall of the room but each motor for the louvers had been disconnected which caused the louvers to not be operable. Each wall mounted louver was covered over with a compressed particle board. Four severed open ended pipes in the ceiling exposed the space above the room and three other separate holes in the ceiling were not firestopped. In addition, combustible materials were stored in the center of the room. Based on interview at the time of the		Doors will be replaced to be self-closing Generator Room will be supplied with outdoor air **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents, staff, and visitors have the potential to be affected. Maintenance Director and Maintenance assistant have been educated on EPS running at rated load, ventilation air flow shall be provided to limit the maximum air temperature in the EPS room to the maximum ambient air temperature required by the EPS manufacturer. Section 7.7.2.1 states ventilation air shall be supplied directly from a source outside the building by an exterior wall opening or from a source outside the building by a 2-hour fire rated air transfer system. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director and Maintenance assistant have been educated on EPS running at rated load, ventilation air flow shall be provided to limit the maximum air temperature in the EPS room to the maximum ambient air temperature required by the EPS manufacturer. Section 7.7.2.1	

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	observations, the Maintenance Director stated he did not know how old the generator was or when it was installed and agreed the room was not separated from other spaces and the room was not supplied with outdoor air. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		states ventilation air shall be supplied directly from a source outside the building by an exterior wall opening or from a source outside the building by a 2-hour fire rated air transfer system. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Maintenance Director/Designee to complete auditing of Generator Room for e EPS running at rated load, ventilation air flow shall be provided to limit the maximum air temperature in the EPS room to the maximum ambient air temperature required by the EPS manufacturer. Section 7.7.2.1 states ventilation air shall be supplied directly from a source outside the building by an exterior wall opening or from a source outside the building by a 2-hour fire rated air transfer system. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	

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