STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155617	A. BUILDING -- B. WING	01/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF CHESTERFIELD SKILLED NURSING FACILITY	524 ANDERSON RD CHESTERFIELD, IN 46017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/24/2023 Facility Number: 000524 Provider Number: 155617 AIM Number: 100267090 At this Emergency Preparedness survey, Waters of Chesterfield Skilled Nursing Facility was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 60 and had a census of 40 at the time of this survey. Quality Review completed on 01/30/23	E 0000	**Name of Provider or Supplier –** The Waters of Chesterfield **ID #**155617 **Address -** 524 Anderson Road, Chesterfield, IN 46017 **Date Survey Completed - 1**/24/23 **DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kimberly Locke	HFA	02/16/2023

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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	§483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its			

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	emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.			

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	(ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific			

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	responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with			

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	their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Administrator and the Maintenance Director on 01/24/2023 at 3:30 p.m., no documentation of annual EEP training and no documentation to show staff could demonstrate knowledge of the EPP was available for review. Based on an interview at the time of records review, the Administrator stated no documentation of the EEP training was available for review. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	E 0037	**E037** – It is the intent of the facility to ensure to conduct annual training for the Emergency Preparedness Program (EPP) to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On 2/6/23 the Administrator and the Maintenance Supervisor/designee updated the Emergency Preparedness Policy Manual to include annual training and to show staff could demonstrate knowledge of the EPP to meet set standards. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. The facility has only one Emergency Preparedness Policy Manual. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 2/6/233 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that the Emergency Preparedness Policy Manual must include annual training and to show staff could demonstrate knowledge of the EPP to meet set standards. b. On 2/10/23 the	02/16/2023

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			Administrator conducted emergency preparedness training with all staff and obtained signed copies of the Emergency Preparedness Policy Manual Certification to be filed in each employee's personnel file and developed a tracking record of emergency preparedness training which includes all current employee names, start dates, dates of initial training and dates of annual training to meet set standards. c. The Administrator and Maintenance Supervisor/designee will review and update the Emergency Preparedness Policy Manual at least annually or as changes occur to meet set standards. if any issues are discovered, they will be addressed and resolved immediately. d. The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. At least annually to ensure compliance, the Administrator and Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual and make changes as necessary to meet set standards. Those reviews will be documented as appropriate.	

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			This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is February 16, 2023.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the			

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	actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.			

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	(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or			

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	(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group			

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	discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated,			

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	clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed			

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	155617	A. BUILDING -- B. WING	01/24/2023

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WATERS OF CHESTERFIELD SKILLED NURSING FACILITY	524 ANDERSON RD CHESTERFIELD, IN 46017

(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
	to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop			

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	exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise			

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	the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			

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	Based on record review and interview, the facility failed to conduct one of the required two exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator	E 0039	**E039 –** It is the intent of the facility to ensure to conduct one of the required two exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 2/14/23 the Administrator and the Maintenance Supervisor/designee conducted a facility based full scale annual exercise and completed documentation for the exercise to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 2/6/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that a facility based full scale annual exercise must be conducted at least annually and documentation retained to meet set standards. b. Maintenance Supervisor/designee will work with the Administrator to ensure a facility based full scale annual exercise is conducted and documented to meet set standards. If any issues are discovered, they will be addressed and resolved immediately.	02/16/2023

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	and the Maintenance Director on 01/24/2023 at 03:30 p.m., no documentation of a facility based annual exercise within the last year was available for review. Based on interview at the time of records review, the Administrator stated that a Table Top exercise was completed on 05/10/2022 but a second exercise was not done in the last 12 months. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		c. The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. At least annually to ensure compliance, the Administrator and Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. Results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is February 16, 2023.**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana	K 0000	**Name of Provider or Supplier –** The Waters of	

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	Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/24/2023 Facility Number: 000524 Provider Number: 155617 AIM Number: 100267090 At this Life Safety Code survey, Waters of Chesterfield Skilled Nursing Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery powered smoke detectors in the resident rooms. The facility has a capacity of 60 and had a census of 40 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 01/30/23		Chesterfield **ID #**155617 **Address -** 524 Anderson Road, Chesterfield, IN 46017 **Date Survey Completed - 1**/24/23 **DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
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			

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	of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 1. Based on observation and interview, the facility failed to ensure 2 of 5 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects 5 residents and 5 staff. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 01/24/2023 at 2:05 p.m., at exit door 2 and exit door 5 there was a privacy curtain installed at each exit that would obstruct egress when fully extended. Based on interview at the time of observations, the Maintenance Director stated that if the the curtain was extended it would obstruct exiting the building. These finding were reviewed with the Administrator and Maintenance Director at the exit interview. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 5 corridor means of egress were continuously maintained free of obstructions. This deficient practice affects 5 staff in the Service Hall. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 01/24/2023 at 2:55 pm in the Service Hall. There was a desk	K 0211	K211 – It is the intent of the facility to ensure corridor means of egresses are continuously maintained free of obstructions to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 1/25/23 the Maintenance Supervisor/designee removed the privacy curtain installed at each exit door 2 and exit door 5 that would obstruct egress when fully extended to meet set standards. The Administrator verified the work on 1/25/23. b. On 1/25/23 the Maintenance Supervisor/designee removed the desk assembly from the service hall; desk was approx. 8 feet long and 3 feet wide being stored in the hallway to meet set standards. The Administrator verified the work on 1/25/23. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 1/25/23 the Maintenance Supervisor/designee inspected all corridor means of egress and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**:	02/16/2023

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	assembly about 8 feet long and 3 feet wide being stored in the corridor. The Maintenance Director stated that someone was supposed to pick it up but had not done so yet. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		a. On 2/6/23 the Administrator inserviced the Maintenance Supervisor/designee and all other staff on the requirement that the corridor means of egress are to remain free of obstructions to meet set standards. b. Maintenance Supervisor/designee will inspect all corridor means of egress throughout the facility weekly for obstructions as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with	

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			subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is February 16, 2023.**	
K 0222 SS=D Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be 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			

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	release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure 1 of 1 exit doors from the kitchen only contained one latching mechanism to release	K 0222	**K222 -** It is the intent of the facility to ensure exit doors from the kitchen only contain one latching	02/16/2023

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	the door and open. LSC 7.2.1.5.10 states a latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions. 7.2.1.5.10.4 states the releasing mechanism shall open the door leaf with not more than one releasing operation. 7.2.1.5.10.1 states the releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches, above the finished floor. This deficient practice could affect staff exiting the kitchen to the dining room. Findings include: Based on observation with the Maintenance Director on 01/24/2023 at 2:55 p.m., a kitchen exit door was equipped with two latching devices, a latching door turn knob and a separate deadbolt lock. Based on interview at the time of observation, the Maintenance Director agreed the kitchen exit door was equipped with two latching devices. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		mechanism to release the door and open to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 1/25/23 the Maintenance Supervisor/designee removed one of the latching devices from the kitchen exit door to meet set standards. The Administrator verified the work on 1/25/23. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 1/25/23 the Maintenance Supervisor/designee inspected all doors to the means of egress to ensure they only contain one latching mechanism to release the door and found no other findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 2/6/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that exit doors from the kitchen only contain one latching mechanism to release the door and open to meet set standards. b. Maintenance Supervisor/designee will inspect all means of egress throughout the facility monthly to ensure exit doors from the kitchen only contain one latching mechanism to release the door as a part of the facility's Preventive Maintenance	

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			Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is February 16, 2023.**	

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K 0223 SS=D 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 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 2 kitchen exit doors to a 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. This deficient practice could affect staff in the kitchen. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 01/24/2023 at 2:30 p.m., the kitchen contained over 62 gallons of trash making the kitchen a hazardous area. The door to the kitchen from the dining room was self-closing, but had a kick down door stop installed on it. This device when used would hold the door open and not release if the fire alarm was activated. Based on interview at the time of observation, the Maintenance Director agreed the door could be held open with this device that would not release with the fire alarm.	K 0223	K223 – It is the intent of the facility to ensure kitchen exit doors to a 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 to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 1/25/23 the Maintenance Supervisor/designee removed the kick down door stop installed on the door to the kitchen from the dining room to meet set standards. The Administrator verified the removal on 2/25/23. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On	02/16/2023

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	This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		1/25/23 the Maintenance Supervisor/designee inspected all doors throughout the facility and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. The Administrator will inservice Maintenance Supervisor & all staff on the requirements to keep doors with self-closing devices in closed position or keep them in open position with approved release device to meet set standards. b. Maintenance Supervisor/designee will inspect all doors throughout the facility monthly to ensure they have self-closing devices in closed position or keep them in the open position with approved release device as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will	

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			be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is February 16, 2023.**	
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, the facility failed to meet 1 of 5 corridors clear width requirement per 19.2.3.4. LSC 19.2.3.4 requires the width of aisles and corridors (clear and 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	K 0232	**K232**– It is the intent of the facility to ensure to meet the corridors clear width requirement per 19.2.3.4 to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On 1/25/23 the	02/16/2023

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	19.2.3.4, exceptions 1-5. This deficient practice could affect about two staff and seven residents. Findings include: Based on observation with the Maintenance Director on 01/24/23 at 2:15 p.m., in the corridor to exit #3, a wooden table that a resident was sitting behind was positioned on one side of the exit access corridor. On the other side of the corridor there was a line of residents in wheelchairs. This left a 3 foot walking area in the corridor. Based on interview at the time of observation, the Maintenance Director, said that the desk was not normally out so far in the corridor. This finding was reviewed with the Administrator and the Maintenance Director at the exit conference. 3.1-19(b)		Maintenance Supervisor/designee removed the wooden table in the corridor to exit #3 to meet set standards. The Administrator verified the removal on 1/25/23. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 1/25/23 the Maintenance Supervisor/designee inspected all corridors throughout the facility to ensure no items were being stored improperly and reducing the width of the corridor and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 2/6/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that no items are to be stored in corridors which would reduce the corridor width to meet set standards. b. On 2/10/23 the Administrator inserviced all other staff on the requirement that no items are to be stored in corridors which would reduce the corridor width to meet set standards. c. Maintenance Supervisor/designee will inspect all exit access corridors throughout the facility weekly to ensure no items are being stored in the corridors which would reduce the corridor width as a part of the facility's Preventive	

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			Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. d. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is February 16, 2023.**	

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K 0291 SS=F 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 records review, observation, and interview, the facility failed to ensure battery backup lights were tested monthly. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents of the facility. Findings include: Based on records review on 01/24/2023 at 10:40 a.m., documentation of the monthly 30 second test for the battery powered emergency lights indicated that from July through December of 2022 there was no record of completion. Based on interview at the time of record review and observation, the Maintenance Director confirmed there was no documentation of the test being done July through December of 2022. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0291	**K291** – It is the intent of the facility to ensure battery backup lights are tested monthly to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 1/18/23 the Maintenance Supervisor/designee conducted the monthly 30 second test for the battery powered emergency lights and documented the results on the Battery-Operated Emergency Lights and signs Test Log to meet set standards. The Administrator verified the work on 1/25/23. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 2/6/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement to provide and maintain emergency lighting to meet set standards. 2.Maintenance Supervisor/designee will conduct the 30-second monthly test as a part of the facility's Preventive	02/16/2023

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			Maintenance Program and document those tests on the Battery-Operated Emergency Lights and signs Test Log and will maintain emergency lighting to meet set standards. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.**	

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K 0321 SS=D Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of 2 laundry corridor doors,	K 0321	**K321**– It is the intent of the facility to ensure laundry corridor doors,	02/16/2023

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	which is a hazardous area greater than 100 square feet, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect staff in the service hall. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 01/24/23 at 2:45 p.m., the laundry room, a hazardous storage room that was greater than 100 square feet, was equipped with self-closing device on the soiled linen corridor door but did not latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director agreed the room was larger than 100 square feet, and stated the door did not latch into the frame. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		which is a hazardous area greater than 100 square feet, is provided with a self-closing device which would cause the door to automatically close and latch into the door frame to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 1/25/23 the Maintenance Supervisor/designee repaired the laundry room door to ensure it latches into the door frame to meet set standards. The Administrator verified the work on 1/25/23. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 1/25/23 the Maintenance Supervisor/designee inspected all hazardous areas for self-closing devices and latch into the door frame and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 2/6/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that all hazardous areas must have self-closing devices and latch into the door frame to meet set standards. b. Maintenance Supervisor/designee will inspect all hazardous area doors throughout the facility monthly to	

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			ensure they have self-closing devices and latch into the door frame as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.**	

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			Our date of compliance is February 16, 2023.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Maintenance Director on 01/24/2023 at 10:30 a.m., the annual fire alarm inspection report was not available for review. There was a semi-annual visual inspection done on 03/04/2022 but no documentation of an annual inspection completed six months later. Based on interview at the time of record review, the Maintenance Director stated that he would call the service provider to fax a copy of the inspection report but the documentation was not provided before the end of the survey.	K 0345	**K345**– It is the intent of the facility to ensure fire alarm systems are maintained in accordance with 9.6.1.3 to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 9/6/22 a licensed fire alarm contractor/designee conducted the annual fire alarm inspection and the semiannual visual inspection and retained documentation in the facilities Life Safety Binder to meet set standards. The Administrator verified the work on 1/25/23. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 2/6/23 the Administrator inserviced the Maintenance	02/16/2023

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	This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		Supervisor/designee on the requirement that fire alarm systems must be maintained in accordance with 9.6.1.3 and annual testing and semi-annual visual inspections on the fire alarm system must be performed to meet set standards. b. Maintenance Supervisor/designee will ensure fire alarm systems are maintained and annual testing and semi-annual visual inspections are performed as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system	

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			components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is February 16, 2023.**	
K 0347 SS=E Bldg. 01	NFPA 101 Smoke Detection Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was installed in accordance with 19.3.4.1. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 17.5.3.1 requires smoke detectors to provide total (complete) coverage that shall include all rooms, halls, storage areas, basements, attics, spaces above suspended ceilings, and other subdivions and accessible spaces, as well as the inside of all closets, elevator shafts, enclosed stairways, dumbwaiter shafts, and chutes. This deficient practice could affect 10 residents in one smoke compartment. Findings include:	K 0347	**K347**– It is the intent of the facility to ensure fire alarm systems are installed in accordance with 19.3.4.1 to meet set standards. **1) CORRECTIVE ACTIONS TAKEN**: a) On 2/14/23 a licensed sprinkler system contractor was contacted to install smoke detectors in the library, by the Activity room to meet set standards. The Administrator verified the quote on 2/14/23. The smoke detector is scheduled to be installed by 2/24/23. **2) ALL OTHERS WITH POTENTIA/L TO BE AFFECTED/**: a) All residents and all staff	02/24/2023

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	Based on observation with the Maintenance Director on 01/24/23 at 2:15 p.m., in the library, open to the corridor, by the Activity room there was no means of smoke detection. Based on interview at the time of observation, the Maintenance Director stated there was no smoke detector in this area. This finding was reviewed with the Adminisrtator and Maintenance Director during the exit conference. 3.1-19(b)		and visitors have the potential to be affected but none were. On 1/25/23 the Maintenance Supervisor/designee inspected all other areas for proper smoke detector coverage and found no other negative findings. **3) MEASURES TO PREVENT REOCCURRENCE**: a) On 2/6/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that areas must be provided with proper smoke detector coverage and installed in accordance with 19.3.4.1 to meet set standards. b) Maintenance Supervisor/designee will inspect all areas throughout the facility monthly for proper smoke detector coverage as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c) The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4) MONITORING CORRECTIVE ACTION**: a) The inspection results will	

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	155617	A. BUILDING 01 B. WING	01/24/2023

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			be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is February 24, 2023.**	
K 0353 SS=C 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			

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	coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 1 of 4 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 01/24/23 at 2:35 p.m. the facility has supervised dry sprinkler systems with four pressure gauges, one of the pressure gauges was dated 2017. No recalibration date information was affixed to the sprinkler system gauge. Based on interview at the time of the observations, the Maintenance Director agreed it was older than five years. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)	K 0353	**K353** – It is the intent of the facility to ensure sprinkler system gauges are replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 1/29/23 a Licensed Sprinkler Contractor/Maintenance Supervisor/designee replaced the pressure gauge that was dated 2017 to meet set standards. The Administrator verified the work on 1/29/23. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 2/6/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that the sprinkler system must be properly maintained to meet set standards. 2.Maintenance Supervisor/designee will ensure the sprinkler systems are maintained and the pressure gauges are tested or replaced every 5 years as a part of the facility's Preventive Maintenance	02/16/2023

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			Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is February 16, 2023.**	

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K 0500 SS=D Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services 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 ensure 2 of 2 fuel fired boilers had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect staff in the mechanical room vicinity. Findings include: Based on record review and observation during a tour of the facility with the Maintenance Director on 01/24/23 at 2:25 p.m., the two boilers in the mechanical room did not have documentation to show that they were inspected within the last two years. Based on interview at the time of the observation, the Maintenance Director stated the inspection documentation for the boilers could not be found. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)	K 0500	**K500**– It is the intent of the facility to ensure fuel-fired boilers have current inspection certificates to ensure the water heaters are in safe operating condition to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. A Certified Water Heater Inspector is scheduled to inspect the two boilers in the mechanical room and provide the facility with Certificates of Inspection to meet set standards. The Administrator verified that the inspection is scheduled to be completed by 3/15/23. 2. **ALL OTHERS WITH POTENTAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. The facility has only four water heaters. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 2/6/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that fuel-fired boilers	03/15/2023

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			must be inspected and a Certificate of Inspection retained at the facility to meet set standards. b. Maintenance Supervisor/designee will check all fuel-fired boilers annually to ensure they are inspected and documentation retained at the facility as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure	

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			compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is March 15, 2023.**	
K 0927 SS=D Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer location was used properly and in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.5.2.3.1(1) states, (transfilling shall occur in) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. This deficient practice could affect all staff in the Service Hall smoke compartment. Findings include: Based on observation with the Maintenance	K 0927	**K927**– It is the intent of the facility to ensure oxygen storage/transfer location is used properly and in accordance with NFPA 99 to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: a. On 2/10/23 the Administrator/DON inserviced all nursing staff on the proper way to use transfilling room and to ensure the door is closed while transfilling is occurring to meet set standards. The Administrator verified this on 2/10/23.	02/16/2023

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	Director during a tour of the facility at 2:50 p.m. on 01/24/23 the oxygen storage/transfer room on the Service Hall of the facility was used by a male employee. The employee entered the oxygen transfilling room, held the door open with his leg, and placed the portable oxygen unit on the oxygen tank, and began to transfer oxygen from the main tank to the portable oxygen tank while he was holding the door to the corridor open. Based on interview at the time of the observation, the employee was asked if this was the normal procedure for transferring oxygen to a portable oxygen tank, and he said it was not. The employee stated that there is normally enough room to close the door before transfilling but there were too many tanks in the oxygen room to allow him to go inside and close the door. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		b. On 1/26/23 the DON removed the additional oxygen tanks from the transfilling room so the door is able to be closed while transfilling is occurring to meet set standards. The Administrator verified this on 1/27/23. **1.ALL OTHERS WITH POTENTAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **2.MEASURES TO PREVENT REOCCURRENCE**: a. On 2/10/23 the DON/designee will monitor the oxygen transfilling procedures to ensure all nursing staff is meeting set requirements per our Oxygen Policy & Procedures to meet set standards. b. The DON will ensure the Oxygen Storage Room has enough space to allow the door to be closed while transfilling is occurring as a part of the facility's Oxygen Storage Room Policy & Procedures and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Oxygen Policy & Procedure and validate the Preventative Maintenance documentation is in place.	

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			1.MONITORING CORRECTIVE ACTION: 1.The inspection results will be presented by the DON monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is February 16, 2023.**	