STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155840	A. BUILDING -- B. WING	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
IGNITE MEDICAL RESORT DYER LLC.	1532 CALUMET AVENUE DYER, IN 46311

(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: 03/28/24 Facility Number: 013462 Provider Number: 155840 AIM Number: 201330210 At this Emergency Preparedness survey, Ignite Medical Resort Dyer LLC was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 100 certified beds. At the time of the survey, the census was 100 Quality Review completed on 04/03/24	E 0000	Ignite Medical Resort Dyer Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. This facility respectfully requests a desk review for the given citations in this survey. Please see all attached documentation for your consideration.	
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: 03/28/24 Facility Number: 013462 Provider Number: 155840 AIM Number: 201330210 At this Life Safety Code survey, the certified	K 0000	Ignite Medical Resort Dyer Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. This facility respectfully requests a	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marnie Davisson	LNHA, VP of Operations	04/20/2024

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	portion of Ignite Medical Resort Dyer LLC, the first floor, 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. This two story facility was determined to be of Type V (111) construction and fully sprinklered. A 2 hour fire wall is provided to divide the facility into two separate buildings. Each separate building is subdivided into two smoke compartments. Separation between the first floor healthcare occupancy and the second floor residential occupancy is provided by a 2 hour horizontal floor/ceiling assembly and fire barriers. The rated floor/ceiling system is supported by 2 hour rated construction. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 100 Comprehensive beds and had a census of 100 at the time of this visit Quality Review completed on 04/03/24		desk review for the given citations in this survey. Please see all attached documentation for your consideration.	
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			

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

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	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 8 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect approximately 30 residents and staff. Findings include:	K 0222	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **Egress door was fixed immediately.** **No harm came to residents or staff related to alleged deficient practice.** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** Thirty residents and staff have the potential to be affected by the alleged deficient practice. Full house audit of all egress doors was completed with no further non-working doors identified. **What measures will be put into place or what systemic**	04/25/2024

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	Based on observation during a tour of the facility with the Director of Environmental Services on 03/28/24 between 09:19 a.m. and 12:43 p.m., the emergency exit doors next to room A152 were equipped with a 15 second delayed egress with signage posted. When the exit doors were tested the irreversible process to release the lock was not initiated. After the delayed egress failed to operate a four digit code was entered to try and release the door without using the delayed egress, however that failed to open the door as well. Three attempts were each made to open the door via entering a code and using the 15 second delayed egress function. Due to the door still failing to open, the fire alarm system was activated to verify the door would open with the fire alarm system. The door initially did not open with the fire alarm, however the Maintenance Assistant who was nearby swiped a card in front of a sensor which released the door while the fire alarm was alarming. Based on interview at the time of observation, the Director of Environmental Services confirmed the door was having issues opening via multiple functions and was unsure why it wasn't opening. The findings were reviewed with the Director of Environmental Services and the Administrator during the exit conference. 3.1-19(b)		**changes will be made to ensure that the deficient practice does not recur; Administrator will educate Director of Maintenance on requirements for egress doors.** Administrator/designee will educate all staff on proper functioning of egress doors and immediate notification to Director of Maintenance/designee if any are not functioning properly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Director of Maintenance/designee will check proper functioning of all egress doors 5x's/week and document findings. Director of Maintenance/designee will present a summary of findings to Quality Assurance Committe monthly x 6 months. Thereafter, if determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of			

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	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			
	Based on observation and interview, the facility failed ensure 1 of 1 kitchen hood extinguishing system provided complete coverage for equipment that produces grease-laden vapors. NFPA 96, 2011 edition, Section 10.1.2 requires cooking equipment that produces grease-laden vapors and that might be a source of ignition of grease in the hood, grease removal device, or duct shall be protected by fire-extinguishing equipment. Section 12.1.2.2 states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. This deficient practice could affect all residents due to the kitchen was located in the same smoke compartment as the main entrance, lobby, and dining room. Findings include:	K 0324	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **Vendor scheduled to visit on 4/24/2024 to provide proper suppression coverage of kitchen equipment.** **No harm came to residents and staff related to the alleged deficient practice.** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents and staff have the potential to be affected by the alleged deficient practice.	04/25/2024

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	Based on observation during a tour of the facility with the Director of Environmental Services on 03/28/24 between 12:44 p.m. and 3:15 p.m., a gas powered griddle and flat top grill both were not completely covered under the kitchen suppression nozzles. One nozzle was pointed towards the backsplash of griddle and one other nozzle was pointed towards the back wall of the hood system. Based on interview at the time of observation, the Director of Environmental Services acknowledged the lack of suppression coverage of the equipment. He further stated he was unsure why the cooking appliances were not completely under the suppression system. Findings were discussed with the Director of Environmental Services and Administrator at exit conference. 3.1-19(b)		Full kitchen audit of equipment was completed to ensure proper coverage for equipment is being provided. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Administrator will educate Director of Maintenance and Executive Chef on provision of complete coverage of kitchen equipment. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Executive Chef/designee will complete observational rounds weekly in the kitchen to ensure proper placement and coverage of kitchen equipment is provided. Executive Chef/designee will present a summary of documented rounds to the Quality Assurance Committee monthly x 6 months. Thereafter, if determined by Quality Assurance Committee, auditing and monitoring will be done quarterly and presented quarterly at the Quality Assurance meeting. Monitoring will be ongoing.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance			

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	Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice affect approximately all staff and residents. Findings include: During record review with the Director of Environmental Services on 03/28/24 between 09:19 a.m., no documentation was provided regarding a visual inspection of the fire alarm system six months after the annual fire alarm inspection conducted on 08/01/23. The facility provided three fire alarm reports over the past 12 months indicating that the system is inspected quarterly.	K 0345	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **Vendor contacted to provide necessary inspection.** No harm came to residents or staff due to alleged deficient practice. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents and staff have the potential to be affected by the same alleged deficient practice. Director of Maintenance/designee scheduled fire protection vendor to provide missing inspection and set up inspections for the year in order to be in compliance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** **Administrator will educate Director of Maintenance on**	04/25/2024

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	Only three inspections were done on 4/14/23, 8/1/23 and 10/18/23. However, no documentation could be found for a fourth quarter inspection which then required a semi-annual inspection. Upon further investigation, the previous alarm company had a set schedule listed in their inspection reports. The alarm company indicated that the set schedule has the fire alarm semi-annual visual inspection done in January of every year and the annual function test was done every July. The other two quarterly inspections were for checking the fire alarm signal and panel. Based on interview at the time of record review, the Director of Environmental Services agreed that a visual inspection of the fire alarm system documentation was missing. He further stated that the facility has gone through a change in ownership and contractors have changed as well. This finding was reviewed with the Director of Environmental Services and Executive Director at the exit conference. 3.1-19(b)		**required documentation of fire alarm inspections.** **Director of Maintenance/designee will ensure fire protection vendor is informed of required inspections and will provide inspections per regulation.** **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** **Director of Maintenance/designee will review documentation monthly to ensure compliance for fire protection inspections.** Director of Maintenance/designee will present summary of documentation to the Quality Assurance committee monthly x 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going.	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be			

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	provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review with the Director of Environmental Services on 03/28/24 between 09:19 a.m. and 12:43 p.m., the fire watch plan did include contacting the regional department of health, however it did not list the contact information for the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. The fire watch policy provided was, according to the Director of Environmental Services, the most updated policy. A second fire watch policy was produced that was used for the previous employers that did have the proper contact information. Based on interview at the time of record review, the Director of Environmental Services confirmed the contact information was not addressed in the updated fire watch policy. This finding was reviewed with the Administrator and Director of Environmental Services during the exit conference.	K 0346	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **No harm occurred to occupants/residents/staff due to the alleged deficient practice.** **Fire watch policy updated to include proper notification of all parties.** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All occupants/residents/staff have the potential to be affected by the alleged deficient practice. Fire watch documentation reviewed to ensure all requirements are present. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** **Administrator will educate Director of Maintenance on proper requirements for the fire watch policy.** Fire watch documentation has been updated to include requirements per regulations. **How the corrective action(s)**	04/25/2024

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	3.1-19(b)		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** **Director of Maintenance/designee will review fire watch policy monthly for proper documentation per regulations.** Director of Maintenance/designee will present fire watch policy to the Quality Assurance committee monthly x 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going.	
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			

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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 record review, observation and interview, the facility failed to maintain 2 of 2 sprinkler systems in accordance with 19.3.5.3. NFPA 25, 2011 Edition, 14.2.1 states except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice could affect approximately all residents and staff. Findings include: Based on record review with the Director of Environmental Services on 03/28/24 between 09:19 a.m. and 12:43 p.m., no documentation could be located during the survey for internal pipe inspections for the dry and wet sprinkler systems. During a tour of the facility between 12:44 and 3:15 p.m., sprinkler system piping was discovered in the riser room and the data room next to resident room C160. Based on interview at the time of record review and observation, the Director of Environmental Services was unaware where the documentation would be and agreed it could not be located during the record review. Findings were discussed with the Director of Environmental Services and Administrator at exit conference. 3.1-19(b)	K 0353	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **No harm came to residents and staff due to the alleged deficient practice.** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents and staff have the potential to be affected by the alleged deficient practice. Required documentation for sprinkler systems was found after Life Safety visit and is in compliance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** **Director of Maintenance/designee will keep required sprinkler system documentation with all other life safety information in order to be tracked for timely scheduling.** Administrator will educate Director of Maintenance on proper documentation requirements and routine maintenance of sprinkler	04/25/2024

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			system. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** **Director of Maintenance/designee will review sprinkler system documentation monthly to ensure all required inspections and routine maintenance are in accordance with regulation guidelines.** Director of Maintenance/designee will present a summary of the audits to the Quality Assurance committee monthly x 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going.	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are			

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	evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect approximately all occupants in the facility. Findings include: Based on records review with the Director of Environmental Services on 03/28/24 between 09:19 a.m. and 12:43 p.m., the fire watch plan did include contacting the regional department of health, however it did not list the contact information for the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and	K 0354	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **No harm occurred to occupants/residents/staff due to the alleged deficient practice.** **Fire watch policy updated to include proper notification of all parties.** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All occupants/residents/staff have the potential to be affected by the alleged deficient practice. Fire watch documentation reviewed to ensure all requirements are present. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** **Administrator will educate Director of Maintenance on proper requirements for the fire watch policy.** Fire watch documentation has been updated to include requirements per regulations. **How the corrective action(s)**	04/25/2024

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	e-mailing it to incidents@isdh.in.gov. The fire watch policy provided was, according to the Director of Environmental Services, the most updated policy. A second fire watch policy was produced that was used for the previous employers that did have the proper contact information. Based on interview at the time of record review, the Director of Environmental Services confirmed the contact information was not addressed in the updated fire watch policy. This finding was reviewed with the Administrator and Director of Environmental Services during the exit conference. 3.1-19(b)		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** **Director of Maintenance/designee will review fire watch policy monthly for proper documentation per regulations.** Director of Maintenance/designee will present fire watch policy to the Quality Assurance committee monthly x 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going.	
K 0363 SS=D 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.			

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	Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure only hold open devices that release when the door is pushed or pulled was used for 1 of 2 Unit Nursing Manager's office corridor doors. This deficient practice could affect approximately 2 staff. Findings include: Based on observation with the Director of Environmental Services on 03/28/24 between 12:44 p.m. to 3:15 p.m., the Unit Manager's office in the Sparkle Hall had the door propped open with a door stop. Based on interview at the time of observation, the Director of Environmental	K 0363	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **Door props were removed immediately.** **No harm came to residents or staff related to the alleged deficient practice.** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	04/25/2024

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	Services confirmed the door was propped open with a door stop. The stopper was removed upon observation. This finding was reviewed with the Administrator and Director of Environmental Services during the exit conference. 3.1-19(b)		**taken;** All residents and have the potential to be affected by the alleged deficient practice. **Full house audit completed to ensure there were no other doors being propped open.** **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Administrator/designee will educate all staff on not propping open doors. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** **Director of Maintenance/designee will conduct weekly facility rounds to ensure that there are no doors propped open.** Director of Maintenance/designee will present a summary of the audits to the Quality Assurance committee monthly x 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going.	
K 0522 SS=E Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device			

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	Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms were provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for approximately all staff within the laundry area and service hall. Findings include: Based on observation with the Director of Environmental Services on 03/28/24 between 12:44 p.m. and 3:15 p.m., the laundry room had fuel-fired dryers with a fresh air intake. The grates for the fresh air intake were in a closed position which prevented air from circulating within the area. When the dryers were ran, the grates were still closed. Based on interview at the time of observation, the Director of Environmental Services was unaware if the grates were electrical louvers which would open when the dryers turned on or if they were purposely closed and unable to open during the survey by hand. He further acknowledged that there is a lack of a proper fresh air intake due to it being obstructed. This finding was reviewed with the Administrator	K 0522	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **The grates in laundry area have been fixed to meet requirements for fresh air intake.** No harm came to residents and staff due to alleged deficient practice. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All staff in laundry area and service hall have the potential to be affected by the alleged deficient practice. All HVAC areas that are to be provided with intake combustion air from outside for rooms containing fuel fired equipment were checked for compliance. **What measures will be put into**	04/25/2024

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	and Director of Environmental Services at the exit conference. 3.1-19(b)		**place or what systemic changes will be made to ensure that the deficient practice does not recur;** Administrator will educate Director of Maintenance on proper fresh air intake requirements for fuel fired equipment. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** **Director of Maintenance/designee will complete observation rounds weekly to ensure grates are working properly.** Director of Maintenance/designee will present a summary of the audits to the Quality Assurance committee monthly x 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going.	
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			

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	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 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 trash receptacles in 1 of 6 corridors were maintained in accordance with 19.7.5.7. This deficient practice could affect approximately 30 residents and staff. Findings include: Based on observations during a tour of the facility with the Director of Environmental Services on 03/28/24 between 12:44 p.m. and 3:15 p.m., there was one 33-gallon soiled linen/trash barrel directly next to another approximate 20 gallon soiled linen receptacle. The two waste receptacles were across from room C141. Based on interview at the time of observation, the Director of Environmental Services agreed that the soiled/linen receptacles were over 32-gallons within a 64 square foot area. The finding was reviewed with the Administrator and Director of Environmental Services during the exit conference. 3.1-19(b)	K 0754	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **Trash receptacles in corridors were moved immediately.** **No harm came to residents and staff due to alleged deficient practice.** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents and have the potential to be affected by the alleged deficient practice. Full house rounding completed to remove all trash receptacles not meeting this requirement. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Administrator/designee will	04/25/2024

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			educate all staff on not keeping trash receptacles in corridors. All trash receptacles are 32 gallons in capacity. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** **Director of Maintenance/designee will complete observational rounds weekly to ensure there are no trash receptacles in corridors.** Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly x 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going.	
K 0918 SS=C 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 safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.			

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	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 record review and interview, the facility failed to exercise the generator for 12 of 12 months to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of	K 0918	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **No harm came to residents or staff affected by the alleged deficient practice.** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents and staff have the potential to be affected by the	04/25/2024

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	8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect approximately all residents and staff. Findings include: Based on review of generator load testing documentation with the Director of Plant Operations from 09:19 a.m. to 12:43 p.m. on 03/28/24, the load information to show the actual load percentage for the diesel powered generator was not documented. Generator load testing before January 2024 did not have any load percentages on the provided forms. The inspections after January 2024 did include a percentage number, however the Director of Plant Operations stated that the percentage listed on the sheets were for the battery load and not the generator output percentage. Based on interview at the time of record review, the Director of Plant Operations acknowledged the missing information. This finding was reviewed with the Administrator and Director of Plant Operations at the exit conference. 3.1-19(b)		alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Administrator will educate Director of Maintenance on proper documentation of facility load test when conducting required generator testing. Vendor has been scheduled to provide proper service for required generator testing and documentation. Documentation has been updated to reflect compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** **Director of Maintenance/designee will conduct testing and complete a review of required documentation monthly.** Director of Maintenance will present a summary of the audits to the Quality Assurance committee monthly x 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going.	

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K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure 3 of 3 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately 4 residents and staff. Findings include: Based on observation during a tour of the facility	K 0920	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **Flexible cords and cables were removed immediately.** **No harm came to residents and staff due to alleged deficient practice.** **How the facility will identify other residents having the**	04/25/2024

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	155840	A. BUILDING 01 B. WING	03/28/2024

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	with the Director of Environmental Services on 03/28/24 between 12:44 p.m. and 3:15 p.m., in resident rooms C167, A132 and C151 all had phone chargers plugged into a lamp which was then plugged into the wall. Based on interview at the time of record review, the Director of Environmental Services confirmed the outlets on the lamp were being used by residents. The finding was reviewed with the Director of Environmental Services and the Administrator during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect approximately staff and an unknown number of residents. Findings include: Based on observation with the Director of Environmental Services on 03/28/24 between 12:44 p.m. and 3:15 p.m., in the Wound Care nurse's office contained a power strip that was used to power equipment, was not secured, and was dangling from the equipments power cords. This condition could put stress on the power cord causing damage to the power cord. Based on		**potential to be affected by the same deficient practice and what corrective action will be taken;** All residents and staff have the potential to be affected by the alleged deficient practice. Full house audit was conducted to remove all electrical equipment that does not meet criteria. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Administrator/designee will educate all staff on proper use of electrical equipment in facility and removal of such when observed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** **Director of Maintenance/designee will conduct rounds on 5 resident rooms and 5 offices weekly to ensure compliance with flexible cords and cables.** Director of Maintenance will present a summary of the audits to the Quality Assurance committee monthly x 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting.	

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	interview at the time of observation, the Director of Environmental Services agreed the power strip was dangling, not secured, and stated the power strip will need to be mounted or set on the floor. This finding was reviewed with the Director of Environmental Services and Administrator during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 2 of 2 power cord daisy chains were not used as and as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. Article 400.8 (1) prohibits daisy chains, because the first extension cord (or power strip) is now acting as a substitute for the fixed wiring of a structure. This deficient practice could affect approximately 3 residents and staff. Findings include: Based on observations during a tour of the facility with the Director of Environmental Services on 03/28/24 between 12:44 p.m. and 3:15 p.m., resident room A153 had a power strip supplying power to an extension cord for decorations. Based on interview at the time of observation, the Director of Plant Operations confirmed the extension cord was plugged into a power strip. Findings were discussed with the Director of Environmental Services and Administrator at exit conference. 3.1-19(b)		Monitoring will be on going.	

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	4. Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately 2 staff and an unknown number of residents. Findings include: Based on observations during a tour of the facility with the Director of Environmental Services on 03/28/24 between 12:44 p.m. and 3:15 p.m., a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in the Central Supply office within the central office area. Based on interview at the time of observation, the Director of Environmental Services acknowledged the high draw power for the power strip and acknowledged it should be plugged into the wall. Findings were discussed with the Director of Environmental Services and Administrator at exit conference. 3.1-19(b)			
K 0930 SS=A Bldg. 01	NFPA 101 Gas Equipment - Liquid Oxygen Equipment Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) Based on observation and interview, the facility failed to protect 1 of over 40 resident sleeping	K 0930	**What corrective action(s) will be accomplished for those**	04/25/2024

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	rooms from the use of liquid oxygen containers stored in a patient bed location or patient care room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.7.4 states the maximum total quantity of liquid oxygen permitted in storage and in use in a patient bed location or patient care room shall be 120 L (31.6 gallons), provided that the patient bed location or patient care room, or both, are separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour in accordance with the adopted building code. LSC Section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. This deficient practice could affect approximately one resident. Findings include: Based on observations with the Director of Environmental Services during a tour of the facility from 12:44 p.m. to 3:15 p.m. on 03/28/24, one liquid oxygen container was stored in resident sleeping Room C146 and was in use for the unit bed location in C146. One resident was observed in the bed location at the time of the observation. The liquid oxygen container was being used by the resident at the time of the observation. Room C146 was not separated from the remainder of the facility by fire barriers having a minimum fire resistance rating of 1 hour because the corridor door to the room was not self-closing or automatic closing. The liquid oxygen tank indicator showed the tank was approximately half full. Furthermore, the room was not secured from unauthorized entry due to the door not being able to be secured. Based on interview at the time of the observation, the Director of Environmental Services agreed the liquid oxygen container was in use with a resident inside. He further stated that he was unaware of		**residents found to have been affected by the deficient practice;** **Liquid oxygen container was removed from resident room immediately.** **No harm came to resident from the alleged deficient practice.** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents and staff have the potential to be affected by the alleged deficient practice. Full house audit conducted to ensure proper compliance with liquid oxygen containers. No other area noted to be out of compliance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Administrator/designee will educate all staff on proper use of liquid oxygen equipment. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** **Director of Maintenace/designee will conduct observational rounds on 5 resident rooms weekly to**	

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	the capacity of the liquid oxygen reservoir. These findings were reviewed with the Administrator and Director of Environmental Services during the exit conference. 3.1-19(b)		**ensure compliance is being maintained.** Director of Maintenance/designee will present a summary of the audits to the Quality Assurance committee monthly x 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going.	