

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155282		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2024	
NAME OF PROVIDER OR SUPPLIER SERENITY SPRING SENIOR LIVING AT NORTHWOOD				STREET ADDRESS, CITY, STATE, ZIP COD 2515 NEWTON ST JASPER, IN 47547			
(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. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 06/04/2024</p> <p>Facility Number: 000180 Provider Number: 155282 AIM Number: 100274190</p> <p>At this Emergency Preparedness survey, Serenity Spring Senior Living at Northwood was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.</p> <p>The facility has 107 certified beds. At the time of the survey, the census was 57.</p> <p>Quality Review completed on 06/13/24</p> <p>The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:</p>			E 0000	<p>The plan of correction is the center's allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.</p> <p>The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p>		
E 0007 SS=F Bldg. --	<p>403.748(a)(3), 416.54(a)(3), 418.113(a)(3), 441.184(a)(3), 482.15(a)(3), 483.475(a)(3), 483.73(a)(3), 484.102(a)(3), 485.625(a)(3), 485.68(a)(3), 485.727(a)(3), 485.920(a)(3), 491.12(a)(3), 494.62(a)(3)</p> <p>EP Program Patient Population</p> <p>§403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3).</p>						
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE				TITLE		(X6) DATE	
Sarah McKenzie				HFA		07/08/2024	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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 disclosable 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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	<p>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:]</p> <p>(3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**</p> <p>*[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.</p> <p>*NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] Based on record review and interview, the facility failed to ensure the emergency preparedness plan addressed the special needs of its client population, including, but not limited to, persons at-risk; the type of services the ICF/IID facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans in accordance with 42 CFR 483.475(a)(3). This deficient practice could affect all occupants.</p>			E 0007	<p>It is the policy of the facility to maintain up to date emergency preparedness plans.</p> <p>1 Emergency management preparedness manual was reviewed and updated on 6/28/2024</p> <p>2 Maintenance director and or designee will review emergency preparedness plans at least</p>		06/28/2024

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E 0037 SS=F Bldg. --	<p>Findings include:</p> <p>Based on record review on 06/04/2024 between 8:45 AM and 12:30 PM with the Maintenance Assistant, the emergency preparedness plan for the facility did not have current information on the patient population or the types of services the facility was able to provide. Based on interview at the time of record review, Maintenance Assistant stated he was not aware of the location of the current patient population or the types of services the facility was able to provide.</p> <p>This finding was reviewed with the Maintenance Assistant at the exit conference.</p> <p>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)</p> <p>EP Training Program</p> <p>§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §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).</p> <p>*[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:]</p> <p>(1) Training program. The [facility] must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services</p>				<p>annually scheduled to begin on 6/28/2024. Patient population and services will be updated as well at least annually.</p> <p>3 Audits will be conducted quarterly by the maintenance director and or designee for 6 months or until compliance is met as well as at quarterly Qapi meetings beginning 6/28/2024.</p>		

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	<p>under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.</p> <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <p>(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.</p> <p>(ii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iii) Provide emergency preparedness training at least every 2 years.</p> <p>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.</p> <p>(v) Maintain documentation of all emergency preparedness training.</p> <p>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the</p>						

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	<p>following:</p> <p>(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.</p> <p>(ii) After initial training, provide emergency preparedness training every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iv) Maintain documentation of all emergency preparedness training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:</p> <p>(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.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(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.</p> <p>(iv) Maintain documentation of all training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.</p> <p>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:</p>						

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	<p>(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.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:</p> <p>(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.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific 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.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p> <p>(i) Initial training in emergency preparedness</p>						

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	<p>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.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.</p> <p>*[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 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 ensure the emergency preparedness training and testing program includes a 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 roles; (ii) Provide emergency</p>			E 0037	<p>1 Training education and documentation will be updated at least annually and kept in a binder.</p> <p>This will be audited quarterly by the maintenance director and or designee for 6 months or until compliance is met as well as at quarterly Qapi meetings</p>		06/28/2024

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E 0039 SS=C Bldg. --	<p>preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review on 06/04/2024 between 8:45 AM and 12:30 PM with the Maintenance Assistant, documentation for staff training on emergency preparedness within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Assistant was unaware of the location of the training for emergency preparedness and was not aware of anyone in the building at the time who had access to the training records.</p> <p>This finding was reviewed with the Maintenance Assistant at the exit conference.</p> <p>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).</p> <p>*[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]:</p>						

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	<p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <p>(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 actual event.</p> <p>(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.</p> <p>(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.</p> <p>*[For Hospices at 418.113(d):]</p>						

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	<p>(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:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(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.</p> <p>(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:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(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:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p>						

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	<p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(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.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(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.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]</p> <p>(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:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual,</p>						

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OMB NO. 0938-039

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	<p>facility-based functional exercise; or</p> <p>(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.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(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.</p> <p>*[For PACE at §460.84(d):]</p> <p>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the PACE experiences an actual natural or man-made emergency that requires</p>						

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	<p>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.</p> <p>(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:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(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.</p> <p>*[For LTC Facilities at §483.73(d):]</p> <p>(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:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the</p>						

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	<p>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.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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 to challenge an emergency plan.</p> <p>(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.</p> <p>*[For ICF/IIDs at §483.475(d)]:</p> <p>(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:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.</p> <p>(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</p>						

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	<p>onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p> <p> (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</p> <p> (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.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or</p>						

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	<p>functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.</p> <p>*[For OPOs at §486.360]</p> <p>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p> <p>(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.</p> <p>(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</p>						

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	<p>needed.</p> <p>*[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. Based on record review and interview, the facility failed to complete after action reports for their annual exercises. 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</p>			E 0039	<p>1 Maintenance director or designee will complete an AAR which will include: A What was suppose to happen B What actually happened C What went well D What can be improved E A plan for incorporating improvement 2 Ensure education and documentation is maintained and updated as needed 3 Maintenance or designee to audit drills, table tops, emergency exercises, and update the Emergency Preparedness Binder as needed quarterly for 6 months or until compliance is met</p>		07/15/2024

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K 0000 Bldg. 01	<p>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.</p> <p>(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 in the facility.</p> <p>Findings include:</p> <p>Based on record review on 06/04/2024 between 8:45 AM and 12:30 PM with the Maintenance Assistant, the facility was unable to provide complete after action reports for their annual emergency preparedness exercises during the last 12 months. Based on interview at the time of record review, the Maintenance Assistant agreed there were no after action reports available for the annual emergency preparedness exercises.</p> <p>This finding was reviewed with the Maintenance Assistant at the exit conference.</p> <p>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).</p> <p>Survey Date: 06/04/2024</p> <p>Facility Number: 000180 Provider Number: 155282</p>			K 0000	<p>The plan of correction is the center's allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.</p>		

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K 0222 SS=E Bldg. 01	<p>AIM Number: 100274190</p> <p>At this Life Safety Code survey, Serenity Spring Senior Living at Northwood 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.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 107 and had a census of 57 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered except a detached garage used for facility storage.</p> <p>Quality Review completed on 06/13/24</p> <p>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</p>				The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.		

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	<p>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.</p> <p>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6</p> <p>SPECIAL NEEDS LOCKING ARRANGEMENTS</p> <p>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.</p> <p>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4</p> <p>DELAYED-EGRESS LOCKING ARRANGEMENTS</p> <p>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.</p> <p>18.2.2.2.4, 19.2.2.2.4</p> <p>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS</p> <p>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.</p>						

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	<p>18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevators 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.</p> <p>18.2.2.2.4, 19.2.2.2.4 1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 2 egress doors on Garden Ridge readily accessible for residents, staff, and visitors. This deficient practice could affect at least 20 residents, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations on 06/04/2024 between 12:30 PM and 5:00 PM with the Maintenance Assistant, the egress door in the Garden Ridge dining room on the east side was unable to be unlocked with the keypad code or by beginning the delayed egress unlocking process. Based on interview at the time of the observation, the Maintenance Assistant agreed the door was unable to be opened using either of the aforementioned methods. The Maintenance Assistant was able to test the fire alarm system and the door was able to be opened upon activation of the fire alarm system.</p> <p>This finding was reviewed with the Maintenance Assistant at the exit conference.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility</p>			K 0222	<p>1 Maintenance asst. placed proper signage and codes on delayed-egress exit doors on 6/5/24</p> <p>2 Maintenance Director or designee to audit doors quarterly for 6 months or until compliance is met to ensure proper signage and codes are up to date.</p>		07/15/2024

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K 0321 SS=F	<p>failed to ensure the means of egress through 3 of 3 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures in Garden Ridge. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect all residents, staff and visitors in this smoke compartment.</p> <p>Findings include:</p> <p>Based on observations on 06/04/2024 between 12:30 PM and 5:00 PM during a tour of the facility with the Maintenance Assistant, the following was noted in Garden Ridge dining:</p> <p>a) 2 of 2 egress doors did not have a code posted to actuate the door release and did not have signage indicating if they were delayed egress doors</p> <p>b) 1 of 1 doors to the main hallway was not posted with the code to actuate the door release</p> <p>Based on interview at the time of the observations, the Maintenance Assistant reported the egress doors were delayed egress and did not have the appropriate signage and that none of the doors in this area had the code posted to allow the doors to be opened.</p> <p>This finding was reviewed with the Maintenance Assistant at the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Hazardous Areas - Enclosure</p>						

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OMB NO. 0938-039

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Bldg. 01	<p>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.</p> <p>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9</p> <p>Area Automatic Sprinkler Separation N/A</p> <p>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)</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 central supply rooms over 50 square feet in size, 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 all residents, staff, and visitors.</p>			K 0321	<p>1 Maintenance installed an auto door closer to supply room door on 6/5/2024.</p> <p>2 Maintenance director or designee to audit door quarterly for 6 months or until compliance is met to ensure proper door closure</p>		07/15/2024

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K 0341 SS=F Bldg. 01	<p>Findings include:</p> <p>Based on observations on 06/04/2024 between 12:30 PM and 5:00 PM with the Maintenance Assistant, the central supply room which contained combustible supplies, including adult diapers, did not have a self-closing mechanism on the door. Based on interview at the time of observation, the Maintenance Assistant agreed the door did not have a self-closing mechanism.</p> <p>This finding was reviewed with the Maintenance Assistant at the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm panels and 1 of 1 fire alarm control panels was protected. NFPA 72, National Fire Alarm and Signaling Code Section 10.10.1 states a means for turning off activated</p>			K 0341	<p>1 Maintenance asst. installed a lock to the fire panel on 6/26/24 2 Maintenance director or designee to audit fire panel quarterly for 6 months or until</p>		07/15/2024

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K 0345 SS=F Bldg. 01	<p>alarm notification appliance(s) shall be permitted only if it complies with 10.10.3 through 10.10.7. Section 10.10.3 states the means shall be key-operated or located within a locked cabinet, or arranged to provide equivalent protection against unauthorized use. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation on 06/04/2024 between 12:30 PM and 5:00 PM with the Maintenance Assistant, the fire alarm command center panel was not locked and the fire alarm panel indicated it was in a trouble state and had a key inserted into the lock. Based on interview at the time of observation, the Maintenance Assistant indicated the room which the fire alarm command panel and fire alarm panel were in was not typically kept locked and agreed the fire alarm command panel was unlocked and a key was in the fire alarm panel. The Maintenance Assistant stated the fire panel had been in a trouble state since the building was struck by lightening in a recent storm and that Koorsen was coming to address the issue.</p> <p>This finding was reviewed with the Maintenance Assistant at the exit conference.</p> <p>3.1-19(b)</p> <p>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,</p>				compliance is met to ensure panel is locked		

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K 0351 SS=E Bldg. 01	<p>National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.</p> <p>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72</p> <p>Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate date and time information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation of the fire alarm control panel and fire alarm panel annunciator on 06/04/2024 at 2:27 PM with the Maintenance Assistant, the fire alarm control panel and fire alarm panel annunciator display indicated it was 06/03/2024 at 11:10 AM. Based on interview at the time of observation, the Maintenance Assistant indicated the facility had been in contact with Koorsen to repair the system as the facility had gotten struck by lightening in a recent storm and agreed the fire alarm panel and fire alarm annunciator were displaying the incorrect date and time.</p> <p>This finding was reviewed with the Maintenance Assistant at the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required</p>			K 0345	<p>1 The fire alarm system had been struck by lightning, Koorsen's was called to repair the system on 6/6/2024.</p> <p>2 Koorsen's was aware and scheduled to be in on 06/05/2024 to repair at their earliest convenience and this was completed on 6/5/2024.</p> <p>3 Maintenance director or designee to audit system to ensure it is working properly and information is up to date quarterly for 6 months or until compliance is met.</p>		06/28/2024

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	<p>by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.</p> <p>In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.</p> <p>19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)</p> <p>1. Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 1 canopies near therapy in accordance with LSC 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in Section 8.5.5.2 and Section 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect all staff, residents, and visitors in the area.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance</p>			K 0351	<p>1 Maintenance removed ceiling fan from sprinkler system. 6/7/2024</p> <p>2 Maintenance removed top shelves to meet compliance on 6/28/2024.</p>		06/28/2024

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	<p>Assistant on 06/04/2024 between 12:30 PM and 5:00 PM, the canopy area near therapy was provided with a ceiling fan which had a blade of the fan directly below a sprinkler head. Based on interview at the time of observation, the Maintenance Assistant agreed the blade of the fan was directly below the sprinkler head and stated the sprinkler head was less than 18 inches from the center of the fan.</p> <p>This finding was reviewed with the Maintenance Assistant at the exit conference.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 1 storage rooms by the slop sink in accordance with LSC 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in Section 8.5.5.2 and Section 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect staff.</p> <p>Findings include:</p> <p>Based on observations on a tour of the facility on 06/04/2024 between 12:30 PM and 5:00 PM with the Maintenance Assistant, the storage room by the slop sink had storage less than 18 inches from the ceiling. Based on interview at the time of observation, the Maintenance Assistant agreed</p>						

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K 0353 SS=F Bldg. 01	<p>there was storage less than 18 from the ceiling in the aforementioned location.</p> <p>This finding was reviewed with the Maintenance Assistant at the exit conference.</p> <p>3.1-19(b)</p> <p>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.</p> <p>a) Date sprinkler system last checked</p> <p>b) Who provided system test</p> <p>c) Water system supply source</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>1. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 room 401 closets, 1 of 2 room 505, 1 of 1 room 104 bathrooms, 1 of 1 dining rooms in Garden Ridge, 1 of 1 room 407 closets, 1 of 1 break rooms, 1 of 1 areas near bathroom B by the break room, and 1 of 1 scale rooms in the Parf hallway. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling</p>			K 0353	<p>1 There are 2 separate sprinkler systems. This facility does not have a fire pump.</p> <p>2 Maintenance inspected sprinkler heads and changed any part with corrosion.</p> <p>3 Maintenance director or designee will audit sprinkler heads quarterly for 6 months or until compliance is met to ensure there</p>		07/15/2024

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	<p>traps hot air and gases around the sprinkler and causes the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect all residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility on 05/13/2024 between 1:00 PM and 5:45 PM with the Maintenance Assistant, the following was observed:</p> <ul style="list-style-type: none"> a. a penetration of 0.5 inches in the closet of room 401 b. a 4 inch penetration and 2 0.5 inch penetrations in the ceiling of the closet in room 407 c. a 1 inch by 1 inch penetration in the ceiling of the break room d. a 0.5 inch penetration in the ceiling by bathroom B near the break room e. a 1/8 inch penetration in the ceiling in the scale room in the Parf hallway f. 2 1-foot penetrations in the ceiling of the Garden Ridge dining room g. 1 of 2 sprinkler heads in room 505 had an escutcheon out of place h. 1 of 1 sprinkler heads in room 404 bathroom was missing an escutcheon <p>Based on interview at the time of the observations, the Maintenance Assistant agreed there were penetrations in the walls in the aforementioned locations and provided the measurements.</p> <p>This finding was reviewed with the Maintenance Assistant at the exit conference.</p>				is no corrosion		

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	<p>3.1-19(b)</p> <p>2. Based on interview and observation, the facility failed to ensure 2 of 6 sprinkler heads in the maintenance shop canopy area covered with rust/corrosion were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect any resident, staff, or visitor while in the area.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility on 06/04/2024 between 12:30 PM and 5:00 PM with the Maintenance Assistant, 2 corroded sprinkler head were located in the maintenance shop canopy area. Based on interview at the time of the observation, the Maintenance Assistant agreed there were 2 corroded sprinkler head were located in the maintenance shop canopy area</p> <p>This finding was reviewed with the Maintenance Assistant at the exit conference.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure all fire pumps were inspected monthly. NFPA 101 at 19.1.1.3.1 states all health</p>						

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K 0363 SS=E Bldg. 01	<p>care facilities shall be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect mostly laundry staff, plus residents in the same smoke compartment.</p> <p>Findings include:</p> <p>Based on record review on 06/04/2024 between 8:45 AM and 12:30 PM with the Maintenance Assistant, the fire pumps on the facility's sprinkler system had not been tested monthly. Documentation of the annual fire pump inspection indicated the fire pump is electric, which requires monthly testing. The only documentation regarding testing of the fire pump available for review was dated 2/2/24 and 11/15/2023. Based on interview at the time of record review, the Maintenance Assistant was unaware of the fire pump needing monthly testing and was unable to locate additional documentation regarding the testing of the fire pump.</p> <p>This finding was reviewed with the Maintenance Assistant at the exit conference.</p> <p>3.1-19(b)</p> <p>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</p>						

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	<p>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.</p> <p>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.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>The facility failed to ensure 1 of 1 Dutch doors met the requirements of 19.3.6.3.13 which requires (1) both the upper leaf and lower leaf to be equipped with a latching device and (2) the meeting edges of the upper and lower leaves to be equipped with an astragal, a rabbet, or a bevel.</p> <p>This deficient practice could affect staff, visitors, and up to 2 residents.</p>			K 0363	<p>1 Maintenance asst installed a metal transitional piece to upper and lower Dutch double door to ensure unit is one 6/6/2024.</p> <p>2 Maintenance director or asst. to audit door to ensure stability and movement quarterly or until compliance is met.</p>		07/15/2024

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PRINTED: 07/10/2024
FORM APPROVED
OMB NO. 0938-039

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NAME OF PROVIDER OR SUPPLIER SERENITY SPRING SENIOR LIVING AT NORTHWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
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K 0372 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on observation during a tour of the facility on 06/04/2024 between 12:30 PM and 5:00 PM with the Maintenance Assistant, the top half of the Dutch door to room 104 was latched into the bottom half instead of each door leaf having its own latching device. The Dutch-door to room 104 also lacked an astragal, rabbet or bevel at the meeting edge of the two door leaves, leaving a gap of 0.5 inches. Based on interview at the time of observation, the Maintenance Assistant agreed each door leaf lacked its own latching device; there was a gap between the 2 halves of the door to room 104 and provided the measurements.</p> <p>This finding was reviewed with the Maintenance Assistant at the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility</p>			K 0372	1 Maintenance used Imperial		07/15/2024

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K 0761 SS=F Bldg. 01	<p>failed to ensure the penetrations caused by the passage of wire and/or conduit through 2 of 9 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect staff and at least 84 residents.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Assistant on 06/04/2024 between 12:30 PM and 5:00 PM, the following unsealed penetrations were discovered:</p> <p>a) a 0.25 inch gap in the smoke wall in activities around wires b) a 3 inch gap in the smoke wall near room 114 conduits</p> <p>This finding was reviewed with the Maintenance Assistant at the exit conference.</p> <p>3.1-19(b)</p>				<p>Silicone Sealant which resists temps up to 600 degrees F and is certified by NSF to fill gaps and holes</p> <p>2 Maintenance director to audit by walk through to ensure holes and gaps are filled quarterly for 6 months or until compliance is met</p>		
	<p>Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of all fire door assemblies were itemized. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed,</p>			K 0761	<p>1 Documentation regarding fire and smoke doors is listed and stored in the facilities fire door binder.</p> <p>2 Audits will be conducted quarterly by the maintenance director and or designee for 6 months or until compliance is met as well as at quarterly qapi meetings beginning 6/28/2024.</p>		06/28/2024

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	<p>labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly.</p> <p>NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified:</p> <p>(1) No open holes or breaks exist in surfaces of either the door or frame.</p> <p>(2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.</p> <p>(3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.</p> <p>(4) No parts are missing or broken.</p> <p>(5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.</p> <p>(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.</p> <p>(7) If a coordinator is installed, the inactive leaf closes before the active leaf.</p> <p>(8) Latching hardware operates and secures the door when it is in the closed position.</p>						

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K 0923 SS=F Bldg. 01	<p>(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.</p> <p>(10) No field modifications to the door assembly have been performed that void the label.</p> <p>(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review on 06/04/2024 between 8:45 AM and 12:30 PM with the Maintenance Assistant, the annual inspection of the fire door assemblies was not itemized. Based on interview at the time of record review, the Maintenance Assistant agreed the annual inspection of the fire door assemblies were not itemized.</p> <p>This finding was reviewed with the Maintenance Assistant at the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101</p> <p>Gas Equipment - Cylinder and Container Storag</p> <p>Gas Equipment - Cylinder and Container Storage</p> <p>Greater than or equal to 3,000 cubic feet</p> <p>Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.</p> <p>>300 but <3,000 cubic feet</p> <p>Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated</p>						

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	<p>from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.</p> <p>A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)</p> <p>Based on observation and interview, the facility failed to ensure a minimum distance of at least 5 feet separated combustible materials from oxygen storage equipment in 1 of 1 oxygen storage rooms NFPA 99, Section 11.3.2.3 requires oxidizing gases such as oxygen shall be separated from combustibles by one of the following: (1) a minimum distance of 20 feet. (2) a minimum distance of 5 feet if the required storage location is protected by an automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. (3) Enclosed</p>			K 0923	<p>1 Maintenance cleaned out all flammable materials next to oxygen tanks 6/6/2024.</p> <p>2. Audits to ensure cleanliness and chemicals will be conducted quarterly by the maintenance director and or designee for 6 months or until compliance is met as well as at quarterly qapi meetings</p>		06/28/2024

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K 0927 SS=F Bldg. 01	<p>cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. This deficient practice could affect any staff, residents, and visitors in the area of the oxygen room.</p> <p>Findings include:</p> <p>Based on observation 06/04/2024 between 12:30 PM and 5:00 PM with the Maintenance Assistant, 21 E cylinders and 7 smaller metal oxygen storage containers were located in the oxygen storage room within 5 feet of other combustible materials, including medical supplies. Based on interview at the time of observation, the Maintenance Assistant agreed there was combustible materials stored within 5 feet of oxygen.</p> <p>This finding was reviewed with the Maintenance Assistant at the exit conference.</p> <p>3.1-19(b)</p> <p>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 room where</p>			K 0927	1 Maintenance installed exhaust motor to air vent in oxygen		07/15/2024

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	<p>oxygen transferring takes place, was provided with properly working mechanical ventilation. NFPA 99, Health Care Facilities, 2012 edition, Section 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical exhaust to maintain a negative pressure in the space continuously. This deficient practice could affect all residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on observation on 06/04/2024 between 12:30 PM and 5:00 PM with the Maintenance Assistant, the oxygen room where oxygen transfilling occurs had 21 E cylinders and 7 smaller metal oxygen containers. There was a mechanically ventilated exhaust fan in the ceiling of this room, however, it was not working at the time of observation. This was acknowledged by the Maintenance Assistant at the time of observation.</p> <p>This finding was reviewed with the Maintenance Assistant at the exit conference.</p> <p>3.1-19(b)</p>				<p>transfilling room on 7/5/24 exhaust motor runs 24/7 and pulls 250-300 CFM</p> <p>2 Maintenance director or designee to audit exhaust motor to ensure it is running properly quarterly for 6 months or until compliance is met</p>		