STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155690	A. BUILDING -- B. WING	09/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF ANDERSON	1821 LINDBERG RD ANDERSON, IN 46012

(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: 09/23/22 Facility Number: 000027 Provider Number: 155690 AIM Number: 100266180 At this Emergency Preparedness survey, Envive of Anderson was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 97 certified beds. At the time of the survey, the census was 44. Quality Review completed on 09/28/22	E 0000		
E 0035 SS=C Bldg. --	483.475(c)(8), 483.73(c)(8) LTC and ICF/IID Sharing Plan with Patients §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. Based on record review and interview, the facility failed to ensure the emergency preparedness plan (EPP) includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.75(c)(8). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator and the Maintenance Supervisor on 09/23/22 between 9:45 a.m. and 11:45: a.m., the Emergency Preparedness Binder provided did not address a method for sharing information contained within the EPP Binder that the facility deems appropriate with clients, their families or representatives. Based on interview at the time of records review, the Administrator agreed the aforementioned policy was not in the provided EPP Binder. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit conference.	E 0035	**E 035** • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **A notice for the emergency preparedness location will be posted at the entrance of the facility with the notice for the survey binder for visitors and family members to see.** • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. **The emergency binder notification will be made available to all the new admissions and all the families and who visits the facility.** • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **The notification will be added to the ISDH survey binder notification where to locate the**	09/30/2022

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			emergency preparedness binder. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **The administrator or maintenance director will audit compliance of the sign daily for 4weeks, 3 time a week for 4weeks and weekly for 4weeks The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.** •	
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: 09/23/22 Facility Number: 000027	K 0000		

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	Provider Number: 155690 AIM Number: 100266180 At this Life Safety Code survey, Envive of Anderson was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in resident rooms on 100, 500 and 600 halls. The facility has a capacity of 97 and had a census of 44 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered except for one detached garage which was not sprinklered. Quality Review completed on 09/28/22			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to maintain latching hardware on 2 of 2	K 0100	**K100** • what corrective action(s)	09/30/2022

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	smoke barrier doors per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect staff and at least 20 residents. Findings include: Based on observations and interview during a tour of the facility with the Administrator and the Maintenance Supervisor on 09/23/22 between 11:45: a.m. and 3:15 p.m., the set of smoke barrier doors in the (1) 400 hall and (2) 300 hall was provided with latching hardware but failed to latch when tested. The door coordinators were not allowing the doors to close. Based on interview at the time of observation, the Administrator and the Maintenance Supervisor agreed the doors were not properly latching when tested and that they needed attention. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit conference. 3.1-19(b)		will be accomplished for those residents found to have been affected by the deficient practice. **The 300 hall and the 400-hall door latching system will be repaired so that they can closed appropriately** • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. **All other fire doors in the facility will be checked for proper closure** . • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **The administrator or the maintenance director will routinely check all the door for proper closure** • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **The administrator or maintenance director will audit these doors daily for 4weeks, 3 time a week for 4weeks and weekly for 4weeks** **The results of these audits will be reviewed by the QAPI committee overseen by the**	

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			Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 8 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview during a tour of the facility with the Administrator and the Maintenance Supervisor on 09/23/22 between 11:45: a.m. and 3:15 p.m., Outside the TV Lounge Exit, on the patio a large gas grill was positioned in such a way blocking access to the exit discharge sidewalk. The Maintenance Supervisor agreed the aforementioned means of egress was not continuously maintained free of all	K 0211	**K 211** • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. T**he grill will be removed from the sidewalk to clear the path for easy access** • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. **All the other exit side walks will be inspected and make sure they are free from any obstruction**.	09/30/2022

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	obstructions or impediments to full instant use in the case of fire or other emergency. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit conference. 3.1-19(b)		• what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **The exit doors to the side walk will be inspected during the facility walk through and any objects obstructing exits will be addressed.** • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **The administrator or maintenance director will audit compliance of the exits for 4weeks, 3 time a week for 4weeks and weekly for 4weeks The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.**	
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			

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	requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the 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			

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	an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 3 of 8 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. 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 over 15, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview during a tour of the facility with the Administrator and the Maintenance Supervisor on 09/23/22 between 11:45: a.m. and 3:15 p.m., the following facility exits had (1) Main Entrance exit door, marked as a	K 0222	**K222** • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **The code to open all the exit doors will be posted where specialized skills will not be needed to locate the code and to use it.** • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. **All the doors in the facility will be checked to make sure that they have the codes posted visibly where no special**	09/30/2022

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	facility exit, was magnetically locked and could be opened by entering a four-digit code but the code was not posted at the exit in a manner which would not require special knowledge to find the code. The code provided at the aforementioned door was hidden behind a board on the aluminum frame and was not visible when standing in front of the code keypad. (2) The Employee entrance, marked as a facility exit, was magnetically locked and could be opened by entering a four-digit code but the code was not posted anywhere. (3) At the TV Lounge Exit door, marked as a facility exit, was magnetically locked and could be opened by entering a four-digit code but the code was not posted anywhere. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit conference. 3.1-19(b)		**skills will be needed to open the door.** • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **The maintenance director will be educated on where to place the door codes for easy accessibility by visitors and everyone coming into the facility.** • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **The administrator or maintenance director will audit the exit doors codes daily for 4weeks, 3 time a week for 4weeks and weekly for 4weeks** **The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved**. • by what date the systemic changes for each	

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			deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation and interview, the facility failed to ensure 1 of 8 corridor means of egresses in building 1 were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following:	K 0232	**K232** • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **The pallet and beds that were obstructing the 600 hallways have been removed and the hallway is clear.** • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective	09/30/2022

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	i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice affects 30 residents in the facility. Findings include: Based on observations and interview during a tour of the facility with the Administrator and the Maintenance Supervisor on 09/23/22 between 11:45: a.m. and 3:15 p.m., the 600 Hall corridor contained 1 large pallet, 2 beds which were obstructing the corridor. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit conference. 3.1-19(b)		action(s) will be taken. **All other hallways in the facility will be inspected for any obstruction.** • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **We will educate the maintenance director to do a facility walk through to make sure the halls are not obstructed**. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **The administrator or maintenance director will check on obstruction of the halls daily for 4weeks, 3 time a week for 4weeks and weekly for 4weeks** • by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of	

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			correction date.	
K 0271 SS=F Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure exit discharge passageways around the facility had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect all residents and staff when exiting the facility. Findings include: Based on observations and interview during a tour of the facility with the Administrator and the Maintenance Supervisor on 09/23/22 between 11:45: a.m. and 3:15 p.m., Immediately outside the (1) TV Lounge Exit and (2) 500 Hall exit, a concrete pad and sidewalk terminate onto a blacktopped path which leads both directions around the facility providing exit discharge to the public way parking lots. Where the concrete sidewalks meet the blacktop pathways there is an uneven surface which could be a trip hazard. Additionally, the aforementioned blacktop pathways are cracked, broken, uneven, and in places narrow creating trip hazards and obstacles during an evacuation. Weeds and grass have grown up through the large cracks in the blacktop creating additional trip	K 0271	**K 271** • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **We will request for a weaver on this citation due to contractor availability** • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and	04/30/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hazards. The Maintenance Supervisor stated that they have been attempting to correct the blacktop pathways, but funding had not been approved and acknowledged that the blacktop walkways were in need of repair to have a complete level walking surface that was free of obstructions leading to the public way. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit conference. 3.1-19(b)		• by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.	
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 1. Based on record review, observation and interview; the facility failed to document annual testing for all battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be	K 0291	K291 • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **The 90 minutes test will be conducted and documented. Also, the exterior emergency lighting will be checked and make sure they are connected to the emergency generator**. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.	09/30/2022

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	155690	A. BUILDING 01 B. WING	09/23/2022

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	fully operational for the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect over 15 residents, staff and visitors. Findings include: Based on records review and interview with the Administrator and the Maintenance Supervisor on 09/23/22 between 9:45 a.m. and 11:45: a.m., annual 90-minute testing documentation for all battery backup lights was not available for review. Monthly testing documentation was available but there was no record of an annual 90-minute test. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit conference. 2. Based on interview and observation, it was determined that the facility failed to provide exterior emergency lighting for all exits. LSC Section 7.9.1.1 requires emergency lighting facilities for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect all occupants in the facility including staff, visitors and residents if the facility were required to evacuate in an emergency and the generator was providing electricity at that time. This deficient practice could affect everyone in the facility. Findings include: Based on observations and interview during a tour of the facility with the Administrator and the Maintenance Supervisor on 09/23/22 between		**All the exits have the potential to be affected by the alleged deficiency** **The administrator or the maintenance director will inspect all the doors to ensure all the lights are connected to the emergency generator**. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **The lighting at the exits will be inspected during load testing of the generator to make sure all the exits are equipped with enough light in case of power outage.** • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **The administrator or maintenance director will audit the lights daily for 4weeks, 3 time a week for 4weeks and weekly for 4weeks** **The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process**	

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	11:45: a.m. and 3:15 p.m., it was unknown if the exterior lights for the exit discharge for all of the facility exits were connected to the generator. The Maintenance Supervisor and the Administrator were unsure and no further verification or documentation to verify the facility's exit lighting was connected to the generator and could illuminate in the event of a power outage. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit conference. 3.1-19(b)		**monitoring and improvement until 100% compliance is achieved.** • by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.	
K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on interview, and observation, the facility failed to ensure propane tanks were stored properly away from all ignition sources. NFPA 58 specifies storage requirements including required separation distances for LP gas containers. This deficient practice could affect 6 staff. Findings include: Based on observations and interview during a tour of the facility with the Administrator and the	K 0300	• what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **The gas grill has been removed and that area is clear without any obstruction.** • how other residents having the potential to be affected	09/30/2022

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	Maintenance Supervisor on 09/23/22 between 11:45: a.m. and 3:15 p.m., the smoking area outside the TV Lounge Exit, contained 1 LP gas container which were consistent with the type used in a residential gas fired outdoor grill. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit conference. 3.1-19(b)		by the same deficient practice will be identified and what corrective action(s) will be taken. **All other doors will be inspected to make sure there are no other gas grills located outside the facility exits**. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **A routine walk through will be done in the facility to make sure no other items are left at the exits.** . • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **The administrator or maintenance director will walk the facility daily for 4weeks, 3 time a week for 4weeks and weekly for 4weeks** **The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.**	

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			• by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. 09/30/2022	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9			

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	Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor doors to 8 of over 12 hazardous rooms were 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 40 residents in three smoke compartments. Findings include: Based on observations and interview during a tour of the facility with the Administrator and the Maintenance Supervisor on 09/23/22 between 11:45: a.m. and 3:15 p.m., the corridor doors to the following hazardous areas, larger than 50 square feet, did not meet the requirements for protection of a hazardous area and were not equipped with self-closing devices: a) 400 Hall Activities/Therapy contained lots of storage, boxes and supplies and was not self-closing. b) Resident Rooms 606, 610, 609, 608, 607 contained storage of chairs, beds and lots of boxes. Based on interview at the time of observation, the Maintenance Supervisor agreed all	K 0321	K321 • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **The following rooms will be equipped to self-close or all the extra items In the rooms removed therapy room, rooms 606,608,607 and 609.** • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. **All the other rooms will be inspected routinely and make sure there are combustible items are accumulated in the rooms,** • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **All the rooms that are being**	09/30/2022

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	aforementioned rooms were hazardous storage areas, and the doors to the rooms were not self-closing. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit conference. 3.1-19(b)		**used a storage will be equipped with self-closure system and the rooms will be monitored for any hazardous materials.** • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **The administrator or maintenance director inspect the rooms daily for 4weeks, 3 time a week for 4weeks and weekly for 4weeks** **The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.** • by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as	

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			possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. 09/30/2022	
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 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 to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchen. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect staff in the kitchen and 25 residents in the dining room.	K 0324	K324 • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **All the dietary staff will be educated on the actions to take if there is a grease fire in the kitchen.**	09/30/2022

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	Findings include: Based on observations and interview during a tour of the facility with the Administrator and the Maintenance Supervisor on 09/23/22 between 11:45: a.m. and 3:15 p.m., the kitchen contained a UL 300 hood system and a K-class fire extinguisher with posted instructions. Based on interview, the facility's only Dietary Manager was asked; what is the correct response if there was a grease fire underneath the hood. The Dietary Manager replied "throw water on it." The Dietary Manager failed to indicate activating the UL 300 hood extinguishing system and using the correct fire extinguisher for a hood grease fire. The Administrator and the Maintenance Supervisor acknowledged the response and stated all kitchen staff will be informed on proper response. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit conference. 3.1-19(b)		• how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. **The dietary manager will be educated on all other equipment's that are being used in the kitchen for life safety**. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **During orientation, the maintenance director will do a walkthrough into the kitchen to identify the life safety equipment's that are being used in the kitchen.** • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **The administrator or maintenance director will quiz the dietary staff on life safety equipment's in the kitchen daily for 4weeks, 3 time a week for 4weeks and weekly for 4weeks** **The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results**	

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			will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.	
K 0341 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm control panels was protected. NFPA 72, National Fire Alarm and	K 0341	• what corrective action(s) will be accomplished for those residents found to have been	09/30/2022

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	Signaling Code Section 10.10.1 states a means for turning off activated 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. Findings include: Based on observations and interview during a tour of the facility with the Administrator and the Maintenance Supervisor on 09/23/22 between 11:45: a.m. and 3:15 p.m., the fire alarm control panel (FACP) door was not locked. During the initial walk through the main FACP was not locked. The Maintenance Supervisor stated that during the construction the FACP was being frequently activated with the dust and they had left it open to conveniently reset. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit conference. 3.1-19(b)		affected by the deficient practice. **The fire alarm control panel has been locked.** • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. **The fire control panels in the facility will be checked to make sure they are equipped with secure locks and the keys are available.** . • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **The fire panels will be included on the daily walk-through inspection of the facility by the maintenance director or designee.** • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **The administrator or maintenance director will audit compliance for 4weeks, 3 time a week for 4weeks and weekly for 4weeks** **The results of these audits will be reviewed by the QAPI committee overseen by the**	

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			Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. • by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.	
K 0345 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition.	K 0345	K345 • what corrective action(s) will be accomplished for those	09/30/2022

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	NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, 17.2 Purpose states, Automatic and manual initiating devices shall contribute to life safety, fire protection, and property conservation by providing a reliable means to signal other equipment arranged to monitor the initiating devices and to initiate a response to those signals. This deficient practice could affect up to 30 residents, staff and visitors. Findings include: Based on observations and interview during a tour of the facility with the Administrator and the Maintenance Supervisor on 09/23/22 between 11:45: a.m. and 3:15 p.m., the following smoke detectors were taped up and completely closed off: 1. The 200 Hall storage area. 2. The Dining Room Hall corridor. 3. The Housekeeping Supply area on 400 Hall. 4. Resident Room 407. The Maintenance Supervisor stated that the smoke detectors were taped closed due to the dust generated by the construction renovation project. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit conference. 3.1-19(b)		residents found to have been affected by the deficient practice. **The tape has been removed from all the smoke alarms**. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. **All other smoke alarms in the facility have the potential to be affected. The alarms in all the rooms will be inspected and any tape around the alarms will be removed.** • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **We will implement a routine audit of the fire alarms in the facility for compliance and this will be on the daily facility walk-through.** • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **The administrator or maintenance director will audit compliance of the fire alarm compliance daily for 4weeks, 3 time a week for 4weeks and weekly for 4week** **The results of these audits will**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. • by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.	
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 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	K 0346	K346	09/30/2022

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	155690	A. BUILDING 01 B. WING	09/23/2022

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	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 and interview with the Administrator and the Maintenance Supervisor on 09/23/22 between 9:45 a.m. and 11:45: a.m., the fire watch plan failed to include contacting the Indiana Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. The provided plan also failed to include the non-emergency phone numbers for contacting the local fire department. Based on interview during the record review, the Maintenance Supervisor acknowledged the fire watch documentation provided stated to contact the Indiana Department of Health at a phone number, and not via the ISDH Gateway link or at the e-mail address listed above and did not provide the contact information for the local fire departments non-emergency number. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit conference. 3.1-19(b)		• what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **The fire watch program will be activated whenever the fire alarms will be covered.** • How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. **All other fire alarm related constructions will be reported to the isdh when ever they are going to be covered for over 4 hours.** • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **The fire watch plan will be updated to include the notification of the isdh through gateway and the secondary mothed that is through email incase the gateway is not operational.** • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **The administrator or maintenance director will audit**	

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			the plan daily for 4weeks, 3 time a week for 4weeks and weekly for 4weeks The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4,			

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	19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in the Nurses Supply Closet in accordance with 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 8.5.5.2 and 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 up to 6 staff. Findings include: Based on observations and interview during a tour of the facility with the Administrator and the Maintenance Supervisor on 09/23/22 between 11:45: a.m. and 3:15 p.m., the Maintenance Office had storage stacked within 18 inches of the ceiling. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned sprinkler heads were obstructed. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit conference. 3.1-19(b)	K 0351	K351 • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **The maintenance office and the other areas will be cleared of any items stacked within 18 inches of the ceiling** • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. **All other areas in the facility have the potential to be affected by the allege deficiency.** **The office and storage area will be inspected for items stored 18 inches from the ceiling in any area of the facility** • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **All the staff will be educated on the storage policies in the facility regarding items near the sprinkler heads cleaning and making sure items are 18inches from the ceilings.** • how the corrective	09/30/2022

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			action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **The administrator or maintenance director will check on the sign daily for 4weeks, 3 time a week for 4weeks and weekly for 4weeks** **The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.** • by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. 09/30/2022	
K 0353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing			

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Bldg. 01	Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure sprinkler heads in the kitchen cooler were not loaded or covered with foreign material in accordance with LSC 9.7.5. 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 7 staff in the kitchen area. Findings include: Based on observations and interview during a tour of the facility with the Administrator and the	K 0353	**K353** The latest completion date on an acceptable POC will be considered the date the facility has alleged compliance. **The sprinkler head in the walk-in closet will be cleaned and dusted to eliminate any sign of loading**. .• what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All sprinkler heads in the facility will be inspected for dust signs of corrosion and signs of loading. • how other residents having the potential to be affected by the same deficient practice will	10/30/2022

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	Maintenance Supervisor on 09/23/22 between 11:45: a.m. and 3:15 p.m., the sprinkler head in the kitchen walk-in cooler was covered in dust or showed signs of loading. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit conference. 3.1-19(b)		be identified and what corrective action(s) will be taken. **All other sprinkler heads in the facility will be cleaned and dusted to eliminate any sign of loading or the corrosion. They will all be inspected for compliance.** • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **The inspection of the sprinkler heads will be included in our monthly quality improvement plan.** • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **The administrator or maintenance director will audit the sprinkler heads daily for 4weeks, 3 time a week for 4weeks and weekly for 4weeks The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued**	

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			recommendations for process monitoring and improvement until 100% compliance is achieved. • by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.	
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 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	K 0354	what corrective action(s) will be accomplished for those residents found to have been affected by the	09/30/2022

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	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 all occupants in the facility. Findings include: Based on records review and interview with the Administrator and the Maintenance Supervisor on 09/23/22 between 9:45 a.m. and 11:45: a.m., the fire watch plan failed to include contacting the Indiana Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. The provided plan also failed to include the non-emergency phone numbers for contacting the local fire department. Based on interview during the record review, the Maintenance Supervisor acknowledged the fire watch documentation provided stated to contact the Indiana Department of Health at a phone number, and not		deficient practice. **All the sprinklers in the facility will be serviced to put all of them back in service.** • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. **All other sprinklers in the facility have the potential to be affected. The sprinkler in all the rooms will be inspected any deficiencies**. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **The functionality of all the sprinkler systems will be inspected and the management of the facility notified of any deficiencies. The policy of the facility will be update to include what to do when the automatic sprinkler system has to be placed on out of service for more than ten hours.** • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **The administrator or maintenance director will audit the sprinkler system daily for**	

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	via the ISDH Gateway link or at the e-mail address listed above and did not provide the contact information for the local fire departments non-emergency number. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit conference. 3.1-19(b)		**4weeks, 3 time a week for 4weeks and weekly for 4weeks The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.** • by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. 09/30/2022	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the			

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	passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, 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 5 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 6 staff 10 residents. Findings include:	K 0363	• what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **The door in the electrical room on the 100 hall, central nursing station, laundry closet on 600**	09/30/2022

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	Based on observations and interview during a tour of the facility with the Administrator and the Maintenance Supervisor on 09/23/22 between 11:45: a.m. and 3:15 p.m., the following corridor doors equipped with a self-closing devices, failed to close and latch positively into the door frame: a) Electrical Room on the 100 hall. b) Central Nurses Station, both doors. c) Clean Laundry Closet 600 Hall. d) 400 hall soiled utility closet, door was sticking on the floor. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit conference. 3.1-19(b)		**hall and soiled utility door on 400 halls will be repaired** . • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. **All other doors in the facility have the potential to be affected by the alleged deficiency.** **All doors in the facility will be inspected for proper functionality** • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **The maintenance director will implement a monitoring program to inspect the doors in the facility for proper latching and closure into the door frame**. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **The administrator or maintenance director will audit compliance of all the doors daily for 4weeks, 3 time a week**	

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			for 4weeks and weekly for 4weeks **The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.** by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. 09/30/2022	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure all electrical panels in the corridors were secured from non-authorized	K 0511	K511 . • what corrective action(s) will be accomplished for those	09/30/2022

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	personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect staff and over 40 residents in 4 corridors. Findings include: Based on observations and interview during a tour of the facility with the Administrator and the Maintenance Supervisor on 09/23/22 between 11:45: a.m. and 3:15 p.m., electrical panels on the 600 hall, Dining Hall, and 500 hall were unlocked when tested. The Maintenance Supervisor stated he will need to have keys made for the electrical panels throughout the facility. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit conference. 3.1-19(b)		residents found to have been affected by the deficient practice **The electrical panels in all the hallways will be locked** • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. **The electrical panels in the entire facility will be inspected if they are locked and have functional locking systems** • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **There will be a regular routine inspection of all the electrical panels for proper locking system.** • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **The administrator or maintenance director will check on the sign daily for 4weeks, 3 time a week for 4weeks and weekly for 4weeks** **The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns,**	

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			trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. • by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. 09/30/2022	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances,			

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	secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview, the facility failed to ensure smoking materials were deposited into ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design in outdoor areas where smoking was taking place. This deficient practice could affect 20 residents. Findings include: Based on observations and interview during a tour of the facility with the Administrator and the Maintenance Supervisor on 09/23/22 between 11:45: a.m. and 3:15 p.m., the following was observed: a) Around the front entrance there were over 30 cigarette butts disposed on the ground in the mulch near the building. b) Outside the Laundry Exit door, there were over 50 cigarette butts on the ground, in and near the rock landscaping. c) Outside the TV Lounge exit door, in the designated smoking area, there were cigarette butts on the ground and on the table.	K 0741	K741. • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **All the entrances of the facility will be cleared of any cigarette butts** • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. **All other areas of the facility that have the potential to be affected will be inspected of cigarette butts.** • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.	09/30/2022

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	e) In and around the parking lot, near the sidewalk leading around the left side of the building, there were numerous cigarette butts on the ground. The Maintenance Supervisor stated that he has been asked to get all the cigarette butts up and occasionally uses a blower to push then together and then collect them. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit conference. 3.1-19(b)		**All the staffs in the facility will be educated on where to smoke and the need to use the ashtrays that are located outside the facility exits for their cigarette butts** • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **The administrator or maintenance inspect all the exits of the facility daily for 4weeks, 3 time a week for 4weeks and weekly for 4weeks The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.** • by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division	

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			needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. 09/30/2022	
K 0761 SS=E Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of at least 1 fire door assembly was completed in accordance of LSC 19.1.1.4.1.1 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, 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, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so	K 0761	K761 • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **The fire doors will be inspected and documented** • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. **All the doors in the facility will be inspected for fire rating** • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **All the doors will be inspected by a certified inspector and documented for ratings** • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality	09/30/2022

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	equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect 20 residents. Findings include: Based on records review and interview with the Administrator and the Maintenance Supervisor on 09/23/22 between 9:45 a.m. and 11:45: a.m., no documentation of an annual inspection for the fire door assembly at the Oxygen Transfilling room was available for review. Based on observation during the facility tour the Oxygen Transfilling room has one 90-minute fire door assembly. Based on interview at the time of records review and observation, the Maintenance Supervisor stated the annual fire door inspection was not completed within the last year and was previously unaware a fire door inspection was needed on the Transfilling Room door.		assurance program will be put into place; and **The administrator or maintenance director will audit the inspection of the doors 4weeks, 3 time a week for 4weeks and weekly for 4weeks The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.** • by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. 09/30/2022	

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	This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit conference. 3.1-19(b)			
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation and interview, the facility failure to ensure 1 of 1 portable space heaters were not used in the facility. This deficient practice could affect up to 3 residents, staff and visitors in the MDS office. Findings include: Based on observations and interview during a tour of the facility with the Administrator and the Maintenance Supervisor on 09/23/22 between 11:45: a.m. and 3:15 p.m., a portable space heater was in use in the MDS office. Based on interview at the time of the observations, the Maintenance Supervisor agreed a space heater was being used and the facility policy stated no space heaters were allowed. The Maintenance Supervisor removed the space heater during the survey. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit	K 0781	K781 • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **The space heater has been removed** • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. **All other areas of the facility will be inspected for space heaters and any other unauthorized electrical items** • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not	09/30/2022

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	conference. 3.1-19(b)		recur. **All the staff will be educated on what items are not to be used in the facility that can cause a fire** • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **The administrator or maintenance director will audit the inspection of the doors 4weeks, 3 time a week for 4weeks and weekly for 4weeks The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.**	
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			

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	the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 2 of 2 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 up to 2 residents and 4 staff. Findings include: Based on observations and interview during a tour of the facility with the Administrator and the Maintenance Supervisor on 09/23/22 between 11:45: a.m. and 3:15 p.m., (1) in the Reception Area a power strip was being used to power a dorm style refrigerator (high power draw equipment). And (2) in the Medical Room near the nurses station, a refrigerator (high power draw equipment) was plugged into a power strip. The Nurse stated that the location of the refrigerator	K 0920	**K920** • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **All the electrical items have been plugged directly into the wall outlet** • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All the areas of the facility will be inspected to make sure they are no extension cords. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.	09/30/2022

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	didn't allow the cord to go directly into the outlet. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit conference. 3.1-19(b)		**The staff will be educated on the use of extension cords in the facility by the administrator or designee** • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **The fire doors will be inspected and documented** • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. **All the doors in the facility will be inspected for fire rating** • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **All the doors will be inspected by a certified inspector and documented for ratings** • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **The administrator or maintenance director will audit the inspection of the doors 4weeks, 3 time a week for 4weeks and weekly for 4weeks** **The results of these audits will**	

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			be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. • by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.	