STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155479	A. BUILDING -- B. WING	08/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KINGSTON CARE CENTER OF FORT WAYNE	1010 W WASHINGTON CENTER RD FORT WAYNE, IN 46825

(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: 08/21/23 Facility Number: 000522 Provider Number: 155479 AIM Number: 100267040 At this Emergency Preparedness survey, Kingston Care Center of Fort Wayne was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 137 and had a census of 99 at the time of this survey. Quality Review completed on 08/23/23	E 0000	The statements made in this plan of correction is not an admission to and do not constitute an agreement with the deficiencies alleged herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance such that an alleged deficiency cited has been corrected by the date indicated. **Please accept the date of correction of 09/07/23 as the facility's credible allegation of compliance. We respectfully request paper compliance for all deficiencies in the following plan of correction.**	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alicia Holifield	HFA	09/07/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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

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

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

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	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 conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on record review with the Maintenance Director and Regional Maintenance Director on 08/21/23 between 09:15 a.m. and 11:56 a.m., there was no documentation to show staff could demonstrate knowledge of the EPP. The only documentation provided was what training was conducted. Based on an interview at the time of records review, the Maintenance Director stated that he did not document staff knowledge of the EPP and stated that it would be added to the program. Findings were discussed with the Regional Maintenance Director and Maintenance Director at exit conference.	E 0037	The facility failed to quiz the staff on annual emergency preparedness staff training. The regional maintenance manager, facility maintenance manager and the facility administrator created. an emergency preparedness quiz see exhibit E-1, this quiz was given out to staff on 8/30/23 to answer and give back to the facility maintenance manager no later than 9/1/23. The annual emergency preparedness staff policy was revised on 8/30/23 with the staff quiz included see exhibit E-2. The facility maintenance manager was in-serviced on the changes made with the annual staff emergency preparedness training on 8/30/23 see exhibit E-3. This annual staff training will be reviewed during the quarterly audit by the regional maintenance manager see exhibit E-4.	09/07/2023

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E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is			

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

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

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

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

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

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	*[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the			

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	following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise			

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	or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that	E 0039	The facility failed to complete the facility drill/event report on the missing resident drill, tornado drill and the bomb threat tabletop exercise that was conducted on 7/20/23 & 8/10/23. The Regional Maintenance	09/07/2023

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	is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Regional Maintenance Director and the Maintenance Director on 08/21/23 between 09:15 a.m. and 11:56 a.m., documentation for the facility-based exercise conducted on 08/09/23 and the additional table-top exercise conducted on 08/09/23 were incomplete. Both exercises did not show if the facility's response was analyzed to ensure the EPP		Manager In-serviced and re-trained the Facility maintenance manager on the emergency preparedness Policy and procedures on 8/30/23 see exhibit E-5. The regional maintenance Manager will audit the EPP during his quarterly audits see exhibit E-4.	

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	policies were effective. Based on interview at the time of records review, the Maintenance Director stated no documentation for analyzing the LTC facility's response was completed and was unaware that an analysis was needed to be completed. Findings were discussed with the Regional Maintenance Director and Maintenance Director at exit conference.			
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: 08/21/23 Facility Number: 000522 Provider Number: 155479 AIM Number: 100267040 At this Life Safety Code survey, Kingston Care Center of Fort Wayne 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 with 410 IAC 16.2. The original one-story facility built in 1981 and the 2013 addition was determined to be of Type V (111) construction and was fully sprinklered. The one-story 2007 addition was determined to be Type II (000) and was fully sprinklered. The facility has a fire alarm system with smoke	K 0000	The statements made in this plan of correction is not an admission to and do not constitute an agreement with the deficiencies alleged herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance such that an alleged deficiency cited has been corrected by the date indicated. **Please accept the date of correction of 09/07/23 as the facility's credible allegation of compliance. We respectfully request paper compliance for all**	

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	detection in the corridors, areas open to the corridors and hard-wired smoke detector in resident rooms with exception of rooms 401 through 405 which contained battery operated smoke alarms. The building is fully protected by a Bi-fuel (natural gas and diesel) powered 300 kW emergency generator. The facility has a capacity of 137 and had a census of 99 at the time of this survey. All areas where the residents have customary access were sprinklered. The facility had a detached un-sprinklered storage building providing facility services which was used for the storage of mowing equipment. Quality Review completed on 08/23/23		**deficiencies in the following plan of correction.**	
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 maintain 1 of 7 exit discharges doors were free of impediments to full instant use in the case of fire or other emergency in accordance with LSC 7.1.10.1. LSC 7.2.1.7.1 states where a door assembly is required to be equipped with panic or fire exit hardware, (3) It shall be constructed so that a horizontal force not to exceed 15 lbf (66 N) actuates the cross bar or push pad and latches. This deficient practice could affect approximately 20 residents and staff in the 200-Hall.	K 0211	The facility failed to ensure that the means of egress exit door on 200 hall met the requirements of LSC 19.2.11 The facility made corrections to the 200 egress door on 8/22/23. The monthly maintenance log was revised on 8/22/23 showing egress door open check and that any	09/07/2023

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	Findings include: Based on observations with the Maintenance Director on 08/21/23 between 12:00 p.m. and 3:05 p.m., the 200-hall exit door by resident room 242 was equipped with panic hardware, but the door would not open on the first try. It took the surveyor two tries to open the door and took excessive force to open with body weight. Based on interview at the time of observation, the Maintenance Director agreed it took excessive force to open the exit door. The findings were reviewed with the Regional Maintenance Director and the Maintenance Director during the exit conference. 3.1-19(b)		Deficiencies will Be corrected immediately see exhibit K-1. The maintenance dept was in-serviced by the regional maintenance manager on the maintenance log revisions on 8/22/23 see exhibit K-2, this will be monitored quarterly by the regional maintenance manager see exhibit E-4.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview; the facility failed to install exit signage in 1 of 2 corridors in the 400 hall in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the	K 0293	The facility failed to ensure that all exit signs had the correct arrow knock-outs removed to allow an appropriate way of egress. The facility replaced the exit sign located at end of 400 hall	09/07/2023

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	egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect 15 staff and residents in B-hall. Findings include: Based on observation with the Maintenance Director on 08/21/23 between 12:00 p.m. and 3:05 p.m., the exit sign located above the entrance doors to the Sun Room indicated occupants to egress left or right away from the emergency exit. Based on observation, it was noted that there was no emergency exit to the left and the path of egress was to the right only. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and confirmed that the path of egress was marked wrong. This finding was reviewed with the Regional Maintenance Director and Maintenance Director at the exit conference. 3.1-19(b)		on 8/22/23 with the proper directional arrow knock-out arrow removed, see exhibit K-3. The monthly maintenance log was revised on 8/22/23 allowing the maintenance person to check exit signs, see exhibit K-1. The maintenance department was In-serviced by the regional maintenance manager on the revisions made to the monthly maintenance log on 8/22/23. See exhibit K-2. The regional maintenance manager will audit the monthly maintenance log and exit signs during his 1/4ly audits see exhibit K-4.	
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 record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of 5 of 5 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained.	K 0300	The facility failed to document the monthly testing of the battery-operated smoke detectors in November & December 2022 and the annual battery changing in September of	09/07/2023

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	NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect approximately 10 staff and residents. Findings include: Based on records review with the Maintenance Director and Regional Maintenance Director on 08/21/23 between 09:15 a.m. and 11:56 a.m., documentation titled "Battery Operated Smoke Detector Maintenance Log for 2022" had missing monthly testing for the months of November and December of 2022. Furthermore, battery replacement for the battery smoke detectors were not documented. Based on interview at the time of record review, the Maintenance Director stated that the batteries of each smoke detector had been replaced within the year, but did not document when they were changed. He further agreed that two months worth of testing were not documented. 3.1-19(b)		2022. The maintenance manager did test and change batteries per his desk Callender but failed to document on the maintenance log see exhibit K-5. The monthly testing and battery changing was placed on the Weekly PM schedule to have the maintenance Assistant to remind manager to test smokes and change the batteries. See exhibit K-6. Battery operated PM schedule and performance will be reviewed by the regional maintenance manager quarterly see exhibit K-7.	
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			

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	Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 7 smoke compartments in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect approximately 20 residents and staff in one smoke compartment Findings include: Based on observations during a tour of the facility with the Maintenance Director and Regional Maintenance Director on 08/21/23 between 12:00 p.m. and 3:05 p.m., in the Main Dining Room near the courtyard entrance doors, there was a missing sprinkler head escutcheon plate that did not completely cover the hole around the sprinkler which left an approximately 1-inch of annular space. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned areas were missing or had	K 0351	The missing escutcheon was replaced on 8/21/23 when discovered during LS survey. The maintenance dept conducted an audit of all sprinkler heads condition and escutcheon rings in place on 8/23. Cleaned heads if needed and replaced escutcheon Rings as discovered see exhibit K-8. A Sprinkler head inspection PM Summary was put in place. See exhibit K-9 and will be monitored by the regional maintenance Manager during the quarterly PM audit see exhibit K-7.	09/07/2023

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	improper installed escutcheons. The escutcheon plate was installed and fixed at the time of the survey. Findings were discussed with the Maintenance Director and Regional Maintenance Director at exit conference. 3.1-19(b)			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 2 of 6 sprinkler heads in the laundry room, 2 of 5 in the Kitchen and 1 of 8 in Main Dining Hall 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	K 0353	The facility conducted an audit on of all sprinkler heads on 8/23 see exhibit K-8 they cleaned the heads mentioned in the 2567, and others that were needed, they also had a contractor change the corroded heads in main kitchen on 9/1 see	09/07/2023

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	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 staff and up to 20 residents in one smoke compartment. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 08/21/23 between 12:00 p.m. and 3:05 p.m. the following sprinkler heads were coved in dust or showed signs of loading, a) One sprinkler head in the Main Dining Hall next to the Training Room was loaded with dirt and lint and could barely see the color of the bulb. b) Two sprinkler heads in the laundry room above the washers and behind the dryer were covered with dust and lint. c) Two sprinkler heads located in the Main Dining Kitchen near the dishwashers were green and showed sign of corrosion. Based on interview at the time of observation, the Maintenance Director confirmed the aforementioned sprinkler heads showed signs of corrosion or had excessive loading. Findings were discussed with the Maintenance Director and Regional Maintenance Director at exit conference. 3.1-19(b)		exhibit K-10. A Sprinkler head inspection PM Summary was put in place. see exhibit K-9 and will be monitored by the regional maintenance manager quarterly PM audit see exhibit K-7.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers			

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	Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers are ready in operable condition. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. This deficient practice could affect approximately 20 residents and staff near in or near the Main Dining Room. Findings include: Based on an observation with the Maintenance Director on 08/21/23 between 12:00 p.m. and 3:05 p.m., the K-Class fire extinguisher located in the Kitchen of the Main Dining Room had signs of corrosion on the end of the nozzle that was green and discolored. This condition could leave the fire extinguisher ineffective and prevent operation. Based on interview at the time of observation, the Maintenance Director agreed that the nozzle of the fire extinguisher showed signs of corrosion and could hinder operation.	K 0355	The K-class extinguisher was taken to our service provider on 9/1, serviced and passed see exhibit K-11. A PM summary was put in place on 9/1 and performed by the regional maintenance manager on all fire extinguishers on 9/1, see exhibit K-12. This will be monitored by the regional maintenance manager quarterly PM audit see exhibit K-14.	09/07/2023

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	155479	A. BUILDING 01 B. WING	08/21/2023

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	This finding was reviewed with the Maintenance Director and Regional Maintenance Director at the exit conference. 3.1-19(b)			
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. 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			

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	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 1 of 11 resident room corridor doors on the 100-Hall were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect approximately 2 residents in room 111. Findings include: Based on observation with the Maintenance Director on 08/21/23 between 12:00 p.m. and 3:05 p.m., the corridor door to resident room 111 did not latch into the frame when tested three times. Based on interview at the time of observation, the Maintenance Director agreed that the door did not latch into the frame and would need adjusted. The finding was reviewed with the Regional Maintenance Director and the Maintenance Director during the exit conference. 3.1-19(b)	K 0363	The facility failed to ensure that all resident room doors closes and latched without obstructions. During the LS survey 1 resident room door failed to latch, the door was fixed on 8/21. We placed resident door check closing, latching without obstruction on a weekly basis see exhibit K 13. This will be monitored by the regional maintenance manager during quarterly PM audit see exhibit K-14.	09/07/2023
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			

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	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 2 of 2 electrical panel in the 100-Hall was secured from non-authorized 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 approximately 20 residents and staff. Findings include: Based on observation with Maintenance Director on 08/21/23 between 12:00 p.m. and 3:05 p.m., the electrical panels in the 100-Hall was unlocked when tested. The panel included breakers to the lights, receptacles, and PTAC units in the 100-Hall resident rooms. Based on interview at the time of observation, the Maintenance Director stated the electrical panel will need to be locked and could not find the key to secure it at the time of observation. Findings were discussed with the Maintenance Director and Regional Maintenance Director at exit conference.	K 0511	The facility maintenance dept, conducted an audit of the facility Looking for any resident accessible electrical Pannels that was unlocked on 9-1 see exhibit K 15. There was 1 on 400 TLA hall and 2 on 100 hall. All were then locked. They placed on daily PM check see exhibit K 16. This will be monitored by the regional maintenance manager during quarterly PM audit see exhibit K-14.	09/07/2023

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K 0522 SS=E Bldg. 01	3.1-19(b) NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 water heater rooms were provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for approximately 20 staff and residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Regional Maintenance Director on 08/21/23 between 12:00 p.m. and 3:05 p.m., the boiler room area within the laundry area had fuel-fired water heaters with a fresh air intake that was covered with lint and dirt. This condition does not allow for fresh air to completely enter the room. Based on an interview at the time of observation, the Maintenance Director stated the intake was covered with lint and would need to be cleaned.	K 0522	The facility maintenance removed all foreign materials from gas fired water heater rooms fresh-air intakes and vents on 8/27 see exhibit K 18. The PM summary was not being followed by The facility maintenance. The regional maintenance manager in-serviced maintenance on 8/22 see exhibit K 17 This will be monitored by the regional maintenance manager during quarterly PM audit see exhibit K-14.	09/07/2023

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	Findings were discussed with the Maintenance Director and Regional Maintenance Director at exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient	K 0920	Maintenance did an audit of facility, removing all surge protectors, extension cords and any 3-way plugs that are non-authorized to be used, and that high powered	09/07/2023

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	practice could affect approximately 5 residents and staff.. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 08/21/23 between 12:00 p.m. and 3:05 p.m., an extension cord was plugged into an outlet near a sink in the Spa Room of 400-Hall. Based on interview at the time of observation, the Maintenance Director and Administrator acknowledged an extension cord was plugged in and removed it upon observation. The finding was reviewed with the Maintenance Director and the Regional Maintenance Director during the exit conference. 3.1-19(b) 2. 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 approximately 5 residents and staff near the Main Entrance. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 08/21/23 between 12:00 p.m. and 3:05 p.m., a refrigerator (high power draw equipment) and microwave was plugged into and supplied power by a power strip in the Human Resource (HR) office and another microwave (high power draw equipment) was plugged into and supplied power by a power strip		equipment are to be plugged directly into a receptacle only, on 8/22 through 8/25, see exhibit K 19. An in-service was given to staff on 9/6 use of extension cords, power cords or 3-way plugs see exhibit K 20. A check will be done by the maintenance staff weekly, using the monthly PM schedule see exhibit K 21. This will be monitored by the regional maintenance manager during the quarterly audit see exhibit K-22.	

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	in the Admissions office. Based on interview at the time of observation, the Maintenance Director acknowledged both power strips. Findings were discussed with the Maintenance Director and Regional Maintenance Director at exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could staff on the storage hall. Findings include: Based on observation with the Maintenance Director on 08/21/23 between 12:00 p.m. and 3:05 p.m., in the Human Resource (HR) office had a power strip used to power a fridge and microwave, was not secured, and was dangling from the outlet on the wall. This condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observations, the Maintenance Director agreed the power strip was dangling, not secured, and stated the power strip will need to be mounted or set on the floor. This finding was reviewed with the Maintenance Director and Regional Maintenance Director			

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	during the exit conference. 3.1-19(b)			