STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155386	A. BUILDING -- B. WING	11/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAURELS OF DEKALB	520 W LIBERTY ST BUTLER, IN 46721

(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: 11/28/22 Facility Number: 000574 Provider Number: 155386 AIM Number: 100266430 At this Emergency Preparedness survey, Laurels of Dekalb 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 101 and had a census of 78 at the time of this survey. Quality Review completed on 11/30/22	E 0000	=”” p=””> The Laurels of DeKalb wishes to have this submitted plan of correction stand as our written allegation of compliance. Preparation and/or execution of this plan does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. Our date of compliance is January 3,2023. =”” p=””>The Laurels of DeKalb is requesting a desk review in lieu of a facility revisit.	
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]:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Emily Nelson	Administrator	12/22/2022

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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	155386	A. BUILDING -- B. WING	11/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAURELS OF DEKALB	520 W LIBERTY ST BUTLER, IN 46721

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	(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 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			

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	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 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			

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	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. (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			

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	(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, 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			

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	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 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			

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	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. *[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.			

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	(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 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)			

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	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 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.			

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	*[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 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	E 0039	**The facility will conduct a community-based exercise to satisfy the regulation.** **The facility's Maintenance Director will ensure the facility will participate in a community-based exercise held on an annual basis.** **Continued compliance will be monitored by the Maintenance Director. Variances will be corrected at the time of observation and trends will be reported to the facility's monthly QA meeting.** **The Administrator is responsible for the continued compliance of the regulation.** /b>	01/03/2023

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	c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator and the Maintenance Director on 11/28/22 at 10:19 a.m., there was documentation of a individual facility-based functional exercise dated 06/30/22, but there was no documentation to show if the facility's response was analyzed to ensure the EPP policies were effective. Also, documentation of an additional annual exercise of choice within the last year was not available for review. Based on interview at the time of records review, the Maintenance Director stated the required exercises were incomplete or have not been conducted. This finding was reviewed with the Administrator and Maintenance Director during the 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).	K 0000	=”” p=””> The Laurels of DeKalb wishes to have this submitted plan of correction stand as our written allegation of compliance.	

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	Survey Date: 11/28/22 Facility Number: 000574 Provider Number: 155386 AIM Number: 100266430 At this Life Safety Code survey, Laurels of Dekalb 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 (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 101 and had a census of 78 at the time of this survey. All areas where residents have customary access were sprinklered. The facility had a detached garage providing facility services including storage of beds, mattresses and snow blowers that was not sprinklered. Quality Review completed on 11/30/22		Preparation and/or execution of this plan does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. Our date of compliance is January 3,2023. ="" p="">The Laurels of DeKalb is requesting a desk review in lieu of a facility revisit.	
K 0271 SS=E 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			

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	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 1 of 7 exit discharge were provided with an unobstructed level walking surface in accordance with NFPA 101 (2012 edition) section 7.7. This deficient practice could affect 20 residents that would use the 200 hall exit. Findings include: Based on observations with the Maintenance Director on 11/28/22 at 12:50 p.m., the first eight feet of the 200-hall exit assault walkway way had dips in the walkway and a one-inch lip that stuck up between the concrete and asphalt. This condition did not provide a level walking surface. Based on interview at the time of observation, the Maintenance Director agreed the walkway did not provide an unobstructed level walking surface. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0271	**The walking surface at the 200 hall exit to be made level for an unobstructed walking surface in accordance to the regulation.** Based on facility fire exit plan residents on 200 hall have potential to be affected. All remaining exits reviewed; no other areas were found to be in violation of the regulation.Continued compliance of the regulation will be monitored by the Maintenance Director though the Preventative Maintenance Program. All variances will be corrected at the time of observation and trends will be reported to the facility's monthly QA Committee, monthly for 3 months. The Administrator is responsible for compliance with this regulation.	01/03/2023
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			

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	155386	A. BUILDING 01 B. WING	11/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAURELS OF DEKALB	520 W LIBERTY ST BUTLER, IN 46721

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	partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 2 of 5 hazardous rooms on the service hall were separated from other spaces by smoke resistant partitions. This deficient practice could affect 20 residents in one smoke compartment Findings include: Based on observations with the Maintenance Director on 11/28/22 at 1:10 p.m., in the mechanical room on the service hall (which contained a fuel fired hot water heater) had a two-inch hole in the ceiling. Also, the soiled utility room on the service hall had a two-inch hole in the ceiling. Based on interview at the time of the observations, the	K 0321	**="" b="">="" b="" maintenance="" director="" completed="" repairs="" to="" 2”="" diameter="" holes="" in="" ceilings="" of="" hall,="" filled="" with="" material="" capable="" resisting="" transfer="" smoke="" maintain="" fire="" resistance="" rating="" ceiling="" barrier. <="">="" b="">=" b="">="" b=">**Maintenance Director completed repairs to the 2" diameter holes in the ceiling of the soiled utility room and mechanical	01/03/2023

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	155386	A. BUILDING 01 B. WING	11/28/2022

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	Maintenance Director agreed both rooms had an unsealed penetration in the ceiling. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		room on service hall, filled with material capable of resisting the transfer of smoke to maintain fire resistance rating of the ceiling smoke barrier. No residents were affected by the alleged deficient practice. **="" b="">="" b="">="" b="">No other ceilings were found to be in violation of this regulation.** ="" b="">="" b="">Continued compliance with the regulation will be completed by the maintenance director through daily rounds and the preventative maintenance program. Variances will be corrected at the time of observation and trends will be reported to the facility's QA meeting, monthly for 3 months. **="" b="">The administrator is responsible for continued compliance of the regulation.** **="" b="">Date of compliance 1/3/2023** **="" b="">** ="" bdate="">	
K 0341 SS=C 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			

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	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 systems was continuously in proper operating condition. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation of the fire alarm control panel with the Maintenance Director on 11/28/22 at 12:44 p.m., the time on the display of the fire alarm control panel indicated the time to be 11:44 a.m. when checked at 12:44 p.m. Based on interview at the time of observation, the Administrator and the Maintenance Director agreed the fire alarm control panel had the wrong time and will need to be changed. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0341	**A visual inspection of the fire alarm system was completed 11/28/2022 and time changed to reflect current time. No residents were affected by the alleged deficient practice.** **All residents have the potential to be affected.** **The facility's TELS system has updated the visual inspection of fire panel to include this regulation. The Maintenance Director is aware of the change to TELS.** **Continued compliance will be monitored by the Maintenance Director. Variances will be corrected at the time of observation and trends will be reported to the facility's monthly QA meeting, monthly for 3 months.** **The Administrator is responsible for the continued compliance of the regulation.** ="" b="">	01/03/2023
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in			

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	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 in the therapy gym was installed in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than five feet above the floor. This deficient practice could affect 8 residents in therapy. Findings include: Based on observations with the Maintenance Director on 11/28/22 at 11:55 a.m., the portable fire extinguisher located in therapy was mounted on the wall with the top of the extinguisher 5 feet 3 inches above the floor. Based on interview at the time of observation, the Maintenance Director agreed the extinguisher was mounted with the top of the extinguisher greater than five feet above the floor. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0355	**Maintenance Director installed the fire extinguisher at correct height, not more than five feet above the floor. No residents were affected by the alleged deficient practice.** **No other fire extinguishers were found to be in violation of the regulation.** **Continued compliance with the regulation will be completed by the Maintenance Director through daily rounds and the Preventative Maintenance Program. Variances will be corrected at the time of observation and trends will be reported to the facility's QA meeting, monthly for 3 months.** **The Administrator is responsible for compliance of the regulation.** /b>	01/03/2023
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in			

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	accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on observation and interview, the facility failed to ensure 5 of 6 egress corridors were not being used as a portion of the return air plenum for heating, ventilating and air conditioning ductwork (HVAC) serving adjoining areas. NFPA 90A 2012 Edition 4.3.12.1.1 Egress corridors in nursing homes and long term care facilities, detention and correctional, and residential occupancies shall not be used as a portion of a supply, return, or exhaust air system serving adjoining arrears. This deficient practice affects the 100, 200, 300 and 400 halls therefore affecting all residents. Findings include: Based on observations with the Maintenance Director on 11/28/22 between 11:30 a.m. to 1:00 p.m., all resident rooms on the 100, 200, 300 and 400 halls were using the egress corridor as a return air system. Based on an interview at the time of observation, the Administrator and the Maintenance Director confirmed the return air was exhausted into the corridor for all resident rooms. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0521	The facility respectfully requests a waiver of K521. The life safety waiver request will be received by the state of Indiana by 12/23/2022.	01/03/2023
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected			

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	and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills or documented orientation training on each shift for 2 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. QSO-20-31 1135 temporary waiver states in lieu of a physical fire drill, a documented orientation training program related to the current fire plan, which considers current facility conditions, is acceptable. The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area (ended 06/07/22). This deficient practice affects all staff and patients. Findings include: Based on record review with the Administrator and Maintenance Director on 11/28/22 at 10:45 a.m., there was no documentation of a completed fire drill for the third shift drill for the first quarter in 2022. Based on interview at the time of record review, the Maintenance Director agreed the third shift drill for the first quarter in 2022 was not conducted. This finding was reviewed with the Administrator	K 0712	**Maintenance Director has been in serviced on requirements for fire drills per guidelines. No residents were affected by the alleged deficient practice.** **All residents have the potential to be affected. Maintenance Director has been in serviced on requirements for fire drills per NFPA 101 fire drill guidelines.** **Administrator or designee to review fire drill documentation monthly as part of the QA meeting to ensure compliance with requirements.** **The QA committee will monitor monthly for 3 months.** /b>	01/03/2023

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	and Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)			
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility failed to ensure trash receptacles in 1 of 5 corridors were maintained in accordance with 19.7.5.7. This deficient practice could affect staff and up to 20 residents in the 300-hall. Findings include: Based on observations with the Maintenance Director on 11/28/22 at 11:50 a.m., there was a soiled linen/trash barrel greater than 32-gallon outside of the soiled utility room on the 300-hall.	K 0754	**On 11/28/2022 Maintenance Director removed 32-gallon barrel from hallway and placed in soiled utility room. No residents were affected by the alleged deficient practice. Based on facility fire exit plan residents on 300 hall have potential to be affected. All remaining corridors reviewed; no other areas were found to be in violation of the**	01/03/2023

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	Based on interview at the time of observation, the Maintenance Director agreed the barrel was greater than 32-gallon and was left unattended in the 300 hall. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**regulation.** **Staff, including maintenance director, will be in serviced on compliance with K754.** **Continued compliance of the regulation will be monitored by the Maintenance Director though the Preventative Maintenance Program. All variances will be corrected at the time of observation and trends will be reported to the facility's monthly QA Committee, monthly for 3 months.** **The Administrator is responsible for compliance with this regulation.** /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, records review, and interview; the facility failure to ensure 1 of 1 portable space heaters were not used in in resident care areas and enforce the space heater policy. This deficient practice could affect up to 8	K 0781	**On 11/28/2022 Maintenance Director removed portable space heater from the therapy gym. No residents were affected by the alleged**	01/03/2023

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	residents, using the therapy gym. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 11/28/22 at 12:00 p.m., a portable space heater was underneath a desk in the therapy gym. Based on records review at 1:15 p.m., the Space Heater Policy stated space heaters are not allowed in the facility. Based on interview at the time of the observations, the Maintenance Director agreed a space heater was in a resident care area, removed the space heater, and stated space heaters are not allowed in the facility. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**deficient practice.** **No other areas were found to be in violation of the regulation.** **On 11/29/2022 the Administrator in-serviced the Rehab Director on the policy including items that are not allowed in the facility.** **Continued compliance of the regulation will be monitored by the Maintenance Director though the Preventative Maintenance Program. All variances will be corrected at the time of observation and trends will be reported to the facility's monthly QA Committee, monthly for 3 months.** **The Administrator is responsible for compliance with this regulation.** /b>	