STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155409	A. BUILDING -- B. WING	07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/18/23 Facility Number: 000537 Provider Number: 155409 AIM Number: 100267270 At this Emergency Preparedness survey, The Waters of Indianapolis was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 81 certified beds. At the time of the survey, the census was 68. Quality Review completed on 07/24/23	E 0000	**August 4, 2023** **Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. We respectfully request a desk review.**	
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: 07/18/23 Facility Number: 000537 Provider Number: 155409 AIM Number: 100267270 At this Life Safety Code survey, The Waters of	K 0000	**August 4, 2023** **Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Fields		08/05/2023

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	Indianapolis 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 and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 81 and had a census of 68 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached building providing storage and a detached smoking shed which were each not sprinklered. Quality Review completed on 07/24/23		**and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. We respectfully request a desk review.**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of			

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	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 1 of over 10 hazardous areas such as Laundries (larger than 100 square feet) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Laundry. Findings include: Based on observations with the Maintenance Director and the Regional Property Manager for Infinity Health Care during a tour of the facility from 12:05 p.m. to 1:50 p.m. on 07/18/23, the corridor door to the washing machine room in the Laundry was held in the fully open position with a magnetic hold open device set to release with fire alarm system activation, latching hardware and a self closing device but the door failed to self close	K 0321	1. 1. The Maintenance Supervisor/designee repaired the self closing device on the corridor door to the washing machine room to ensure it self closes and latches fully into the frame to meet set standards. 2. 2. All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee inspected all hazardous area doors for self closing devices and found no other negative findings. 3. 3. The Maintenance Supervisor was educated on the requirement that all hazardous area doors must be protected with a self-closing device that self closes and latches into the frame to meet set standards.	08/26/2023

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	and latch into the door frame when tested to close multiple times. The latching mechanism on the door failed to protrude into the latching plate on the door frame. Based on interview at the time of the observations, the Maintenance Director agreed the washing machine room in the Laundry was not separated from other spaces with smoke resistant partitions and doors. These findings were reviewed with the Administrator, the Maintenance Director and the Regional Property Manager for Infinity Health Care during the exit conference. 3.1-19(b)		4. 4. Maintenance Supervisor/designee will inspect all hazardous area doors throughout the facility monthly to ensure there is a self-closing device and that it closes and latches into the frame as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. The inspection results will be presented by the Maintenance Supervisor/designee will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. Monitoring will continue for a minimum of six months until substantial compliance is achieved.	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for			

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	Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review and interview, the facility failed to ensure repair documentation was available for review to ensure 1 of 1 kitchen range hood exhaust systems was maintained in proper working order. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition, Section 4.1.3 states the following equipment shall be kept in working condition: (1) Cooking equipment (2) Hoods (3) Ducts (if applicable) (4) Fans (5) Fire-extinguishing equipment (6) Special effluent or energy control equipment Section 4.1.3.1 states maintenance and repairs shall be performed on all components at intervals necessary to maintain good working condition. This deficient practice could affect over two kitchen staff.	K 0324	**1.** The facilities certified kitchen range hood Contractor corrected the deficiencies noted on the job service report of the kitchen range hood exhaust system inspection including remounting/replacing the exhaust fan motor brackets and installing new filters to meet set standards. 2. All residents and all staff and visitors have the potential to be affected but none were. 3. The Maintenance Supervisor was educated on the requirement that all deficiencies noted on the contractor's inspection report of the kitchen range hood exhaust system need to be corrected to meet set	08/26/2023

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	Findings include: Based on review of the kitchen range hood exhaust system inspection contractor's "Job Service Report" documentation dated 03/10/23 with the Maintenance Director and the Regional Property Manager for Infinity Health Care during record review from 9:10 a.m. to 12:05 p.m. on 07/18/23, deficiencies were noted with the kitchen range hood exhaust system. The "Notes" section of the 03/10/23 inspection report stated "exhaust fan motor brackets need replaced or re-mounted. Fan blades move too frequently. Need new filters as well". Based on interview at the time of record review, the Regional Property Manager for Infinity Health Care stated the deficiencies found on the 03/10/23 have been corrected but agreed repair documentation on or after 03/10/23 was not available for review at the time of the survey. These findings were reviewed with the Administrator, the Maintenance Director and the Regional Property Manager for Infinity Health Care during the exit conference. 3.1-19(b)		standards. 4. The facilities certified kitchen range hood Contractor will inspect the kitchen range hood exhaust system and correct any deficiencies noted as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results and present the findings at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. Monitoring will be monthly for a minimum of six months.	
K 0372 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC			

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	systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. 1. Based on observation and interview, the facility failed to ensure openings through 1 of 1 ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes, and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director and the Regional Property Manager for Infinity Health Care during a tour of the facility from 12:05 p.m. to 1:50 p.m. on 07/18/23, the following was noted: a. the annular space surrounding three electrical conduits which penetrated the ceiling smoke barrier in the former emergency generator room in the Maintenance Office was not firestopped. b. foam was used to firestop the ceiling penetrations of conduits above the new automatic transfer switch in the electrical room across from Room L2. Based on interview at the time the	K 0372	1. The Maintenance Supervisor/designee used a one hour fire rated material to seal the gap in the former emergency generator room in the maintenance office to meet set standards. The Maintenance Supervisor/designee used a one hour fire rated material to seal the ceiling penetrations of conduits above the new automatic transfer switch in the electrical room across from room L2 to meet set standards. The Maintenance Supervisor/designee used a one hour fire rated material to seal the annular space surrounding a one inch in diameter electrical conduit which penetrated the attic smoke barrier wall above the corridor door set by Room L2 to meet set standards. 2. All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee inspected all smoke barrier walls & ceilings throughout the facility for penetrations and found no other negative findings. 3. The Maintenance	08/26/2023

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	observations, the Maintenance Director stated he was not aware of the fire resistance rating of the foam used to firestop the ceiling penetrations. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned openings did not ensure the ceiling smoke barrier was protected to maintain the fire resistance rating of the smoke barrier. These findings were reviewed with the Administrator, the Maintenance Director, and the Regional Property Manager for Infinity Health Care during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 3 smoke barrier walls was protected to maintain the fire resistance rating of the smoke barrier wall. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect over 30 residents, staff, and visitors in the vicinity of Room L2. Findings include: Based on observations with the Maintenance Director and the Regional Property Manager for Infinity Health Care during a tour of the facility from 12:05 p.m. to 1:50 p.m. on 07/18/23, the annular space surrounding a one inch in diameter electrical conduit which penetrated the attic smoke barrier wall above the corridor door set by Room L2 was not firestopped. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned opening in the attic smoke barrier wall above the corridor door set by Room L2 was not firestopped to maintain		Supervisor was educated on the requirement that smoke barrier walls & ceilings must be free of penetrations and voids to meet set standards. 4. Maintenance Supervisor/designee will inspect all smoke barrier walls & ceilings throughout the facility monthly for penetrations and voids as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the inspection results with the Administrator and Quality Assurance/Performance Improvement (QA/PI) meeting for a minimum of six months. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	

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	the fire resistance rating of the smoke barrier wall. These findings were reviewed with the Administrator, the Maintenance Director, and the Regional Property Manager for Infinity Health Care during the exit conference. 3.1-19(b)			
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure wall mounted electrical outlet boxes in 2 of 42 resident sleeping rooms was protected. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. Article 406.5, states receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect over 4 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and the Regional Property Manager for Infinity Health Care during a tour of the facility from 12:05 p.m. to 1:50 p.m. on 07/18/23, the wall mounted outlet box nearest the corridor door in Room H8 was missing its cover plate. The resident bed and an operating oxygen	K 0511	1. 1. The Maintenance Supervisor/designee repaired the two outlet boxes that were missing a cover plate in room H8 & H10 to meet set standards. 2. 2. All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor inspected all electrical outlets and noted no other negative findings. 3. 3. The Maintenance Supervisor was educated on the requirement that electrical outlets must be installed with a cover plate to meet set standards. 4. 4. The Maintenance Supervisor/designee will inspect all outlet boxes monthly to ensure they have a cover plate and	08/26/2023

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	concentrator were plugged into the outlet box. In addition, two of the four screws for the wall mounted quad outlet box nearest the corridor door in Room H10 were loose causing the cover plate for the quad outlet box to not completely cover the opening of the outlet box. Based on interview at the time of the observations, the Maintenance Director agreed the two outlet boxes were not completely covered with a cover plate. These findings were reviewed with the Administrator, the Maintenance Director and the Regional Property Manager for Infinity Health Care during the exit conference. 3.1-19(b)		document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting for a minimum of six months. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	
K 0521 SS=E Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation and interview; the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance within the most recent four year period in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A,	K 0521	**1.** **1.** The facilities certified fire damper contractor corrected the deficiencies noted on the June 2023 fire damper inspection report to meet set standards. 2. 2. All residents and all staff and visitors have the potential to	08/26/2023

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	Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. The test and inspection frequency shall be every 4 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. Section 19.4.3 states full unobstructed access to the fire damper shall be verified and corrected as required. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the fire damper inspection contractor's "Fire Damper Inspection Checklist" documentation dated June 2023 with the Maintenance Director and the Regional Property Manager for Infinity Health Care during record review from 9:10 a.m. to 12:05 p.m. on 07/18/23, a total of 115 fire dampers in the facility were inspected and tested within the most recent four year period. Review of the June 2023 fire damper inspection documentation also indicated 15 fire damper locations did not operate correctly and two fire damper locations need repairs to "needs to have sheet metal to fill gaps". Additional documentation to indicate when and how the deficiencies were corrected was not available for		be affected but none were. 3. 3. The Maintenance Supervisor was educated on the requirement that all fire dampers throughout the facility must be inspected at least every 4 years and necessary maintenance and deficiencies must be completed to meet set standards. 4. 4. The Maintenance Supervisor will work with the facilities fire damper contractor to ensure fire dampers throughout the facility are inspected every 4 years and necessary maintenance and deficiencies are completed as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results and will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting for a minimum of six months. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	

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	review. Based on interview at the time of record review, the Regional Property Manager for Infinity Health Care stated parts for fire damper repair are "on order" and should be corrected "within 7-10 days". Review of the June 2023 fire damper inspection documentation indicated fire damper location "1" at the "Front Entrance" was one of the 17 fire damper locations which failed inspection and testing. Fire damper location "1" had no fusible link and did not operate correctly when tested. Based on observations with the Maintenance Director and the Regional Property Manager for Infinity Health Care during a tour of the facility from 12:05 p.m. to 1:50 p.m. on 07/18/23, the fire damper location on the ceiling at the front entrance vestibule had an affixed maintenance sticker by the inspection contractor indicating it was damper "1". The shutter for the fire damper was in the fully closed position as the fire damper appeared to have no fusible link in place to hold the shutter in the fully open position. These findings were reviewed with the Administrator, the Maintenance Director and the Regional Property Manager for Infinity Health Care during the exit conference. 3.1-19(b)			
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required			

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	of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Disaster Preparedness Manual - Fire Plan and Fire Prevention" documentation dated 05/16/23 with the Maintenance Director and the Regional Property Manager for Infinity Health Care during record review from 9:10 a.m. to 12:05 p.m. on 07/18/23, the written fire safety plan for the facility did not address the location of fire barrier doors and smoke barrier doors in the facility. The fire plan documentation stated "horizontal evacuation, which is the type of evacuation used first, consists of moving patients down the corridor through at least 1 set of fire doors to a	K 0711	1. 1. The Maintenance Supervisor updated the facilities written fire safety plan to address the location of fire barrier doors and smoke barrier doors on the facilities floor plan which is a part of the facilities Emergency Preparedness Policy and Procedures Manual to meet set standards. 2. 2. All residents, staff and visitors have the potential to be affected but none were. 3. 3. The Maintenance Supervisor educated staff on the updated written fire safety plan to include fire barrier doors and smoke barrier doors to meet set standards. 4. 4. The Maintenance Supervisor will review the fire safety floor plan to include fire barrier doors and smoke barrier doors to meet set standards. The Administrator will monitor adherence to the Preventive Maintenance Policy Manual and the Emergency Preparedness Policy Manual. Findings will be presented at the monthly quality assurance/performance improvement (QA/PI) meeting for a minimum of six months. Inspection results and system	08/26/2023

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	safe area" and to "evacuate all persons to unaffected area of building, beyond the nearest smoke barrier doors" and to "assist with evacuation as directed - move residents beyond fire doors". Based on interview at the time of the record review, the Maintenance Director agreed the written fire safety plan for the facility did not address the location of fire barrier doors and smoke barrier doors in the facility. These findings were reviewed with the Administrator, the Maintenance Director and the Regional Property Manager for Infinity Health Care during the exit conference. 3.1-19(b)		components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	
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 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 1. Based on record review and interview, the facility failed to provide documentation of a fire drill conducted on the third shift for 1 of 4 quarters. This deficient practice affects all residents, staff and visitors. Findings include:	K 0712	1. The Maintenance Supervisor/designee conducted a fire drill for each of the three shifts and documented the results in the facilities Life Safety Binder to meet set standards. 2. All residents and all staff and	08/26/2023

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	Based on review of "Fire Drill Report" documentation with the Maintenance Director and the Regional Property Manager for Infinity Health Care during record review from 9:10 a.m. to 12:05 p.m. on 07/18/23, documentation of a fire drill conducted on the third shift in the first quarter (January, February, March) 2023 was not available for review. Based on interview at the time of record review, the Maintenance Director stated the facility operates three shifts per day, the third shift fire drill conducted on 04/01/23 at 10:30 p.m. was intended to be the third shift/first quarter 2023 fire drill but agreed documentation of a fire drill conducted on the third shift in the first quarter 2023 was not available for review. These findings were reviewed with the Administrator, the Maintenance Director and the Regional Property Manager for Infinity Health Care during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to document activation of the fire alarm system on fire drills conducted between 6:00 a.m. and 9:00 p.m. for 1 of 4 quarters. LSC 19.7.1.4 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Report"		visitors have the potential to be affected but none were. 3. The Maintenance Supervisor was educated on the requirement that fire drills must be conducted at unexpected times under varying conditions at least quarterly on each shift and documented to meet set standards. Documentation will be retained in the facility's Life Safety Binder as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. 4. The Maintenance Supervisor/designee will review with the Administrator the inspection results and the inspection results will be presented at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting for a minimum of six months to ensure compliance is maintained.	

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	documentation with the Maintenance Director and the Regional Property Manager for Infinity Health Care during record review from 9:10 a.m. to 12:05 p.m. on 07/18/23, documentation for the third shift fire drill conducted on 12/30/22 at 6:30 a.m. indicated the drill was conducted after 6:00 a.m. but before 9:00 p.m. and did not include activation of the fire alarm system and transmission of the fire alarm signal at the time of the fire drill. The aforementioned third shift fire drill documentation stated "Silent Alarm" but the fire alarm system was activated at 8:30 a.m. on 12/30/22. Based on interview at the time of record review, the Maintenance Director stated the facility operates three shifts per day and agreed documentation for the aforementioned third shift fire drill conducted after 6:00 a.m. but before 9:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal at the time of the fire drill. These findings were reviewed with the Administrator, the Maintenance Director and the Regional Property Manager for Infinity Health Care during the exit conference. 3.1-19(b)			
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be			

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	posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on record review, observation and interview; the facility failed to ensure smoking materials were deposited into ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design in 1 of 2 outdoor areas where smoking was taking place. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the outdoor smoking area in the exit discharge for Hope Hall. Findings include: Based on review of "Smoking Policy" documentation with the Maintenance Director and the Regional Property Manager for Infinity Health Care during record review from 9:10 a.m. to 12:05 p.m. on 07/18/23, smoking will be allowed for residents, staff and visitors in designated outdoor areas only which are provided with ashtrays made	K 0741	1. 1. **T**he Maintenance Supervisor removed the open top metal bucket stored in the exit for Hope Hall outside resident sleeping room H6 at the north side of the facility and installed ashtrays and metal containers with self-closing cover devices to meet set standards. 2. 2. All residents, staff and visitors have the potential to be affected but none were. 3. 3. All staff were educated on the requirement that cigarette butts must be put in the metal container with a self-closing device to meet set standards. 4. 4. The maintenance director/designee will monitor exit for Hope Hall outside resident	08/26/2023

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	of noncombustible material and of safe design and are also provided with metal containers with self-closing covers into which ashtrays can be emptied. Based on observations with the Maintenance Director and the Regional Property Manager for Infinity Health Care during a tour of the facility from 12:05 p.m. to 1:50 p.m. on 07/18/23, well over 50 extinguished cigarette butts were deposited into an open top metal bucket stored in the exit discharge for Hope Hall outside resident sleeping Room H6 at the north side of the facility. Based on interview at the time of the observations, the Maintenance Director agreed cigarette butts were not deposited into ashtrays and metal containers with self-closing cover devices at this outdoor location where smoking was taking place. These findings were reviewed with the Administrator, the Maintenance Director and the Regional Property Manager for Infinity Health Care during the exit conference. 3.1-19(b)		sleeping room H6 at the north side of the facility to ensure cigarette butts are being put into the metal container with a self-closing device as a part of the facility's Smoking Policy and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results and will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting for a minimum of six months to ensure compliance is maintained.	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of			

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	less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review and interview, the facility failed to ensure documentation of electrical outlet receptacle testing for all resident sleeping rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet,	K 0914	**1.** **1.** The Maintenance Supervisor/designee conducted the annual inspection of the electrical receptacles installed in resident sleeping rooms throughout the building including an itemized list per each location and documented the results on the Annual Receptacle Testing Log to meet set standards. 1.All residents, staff and visitors have the potential to be affected but none were. **2.T**he Maintenance Supervisor/designee on the requirement that electrical receptacles in resident sleeping rooms must be tested annually including an itemized list per each location and documented on the Annual Receptacle Testing Log to meet set standards. 4. 4. The Maintenance Supervisor/designee will ensure to properly test electrical receptacles installed in resident sleeping rooms throughout the building	08/26/2023

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	the performance requirements of this chapter. This could affect all residents. Findings include: Based on review of "Annual Receptacle Testing Log" documentation dated June 2023 with the Maintenance Director and the Regional Property Manager for Infinity Health Care during record review from 9:10 a.m. to 12:05 p.m. on 07/18/23, electrical receptacle inspection and testing documentation was incomplete. The 2023 receptacle testing documentation only listed resident sleeping rooms which were tested but did not itemize the location of each receptacle location tested in the room. Based on interview at the time of record review, the Maintenance Director stated each resident sleeping room has multiple receptacle locations and agreed electrical receptacle inspection and testing documentation for the most recent twelve month period was incomplete. These findings were reviewed with the Administrator, the Maintenance Director and the Regional Property Manager for Infinity Health Care during the exit conference. 3.1-19(b)		annually including an itemized list per each location as part of the facility's Preventive Maintenance Program and document those inspection results on the Annual Receptacle Testing Log as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The results will be presented by the Maintenance Supervisor/designee to the Administrator and will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting for a minimum of six months to ensure compliance is maintained.	