STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155176	A. BUILDING -- B. WING	12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLENBROOK REHABILITATION & SKILLED NURSING CENTER	3811 PARNELL AVE FORT WAYNE, IN 46805

(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: 12/12/22 Facility Number: 000092 Provider Number: 155176 AIM Number: 100266090 At this Emergency Preparedness survey, Glenbrook Rehabilitation and Skilled Nursing Center was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 82 and had a census of 57 at the time of this survey. Quality Review completed on 12/13/22	E 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a post survey revisit on or after February 18, 2023.	
E 0039 SS=C 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

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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):]			

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	(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 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			

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	(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. (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,			

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	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, 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			

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	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 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			

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	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. *[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			

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	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 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			

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	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 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			

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	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 provide complete documentation for the second exercises of choice to test the Emergency Preparedness Plan (EPP). 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	Glenbrook Rehabilitation & Skilled Nursing Center will complete documentation related to actual disaster that occurred in April 2022. In addition, the tabletop exercise will be repeated by February 18, 2023 with complete documentation and review of policies. Glenbrook Rehabilitation will maintain continued efforts to ensure drills/exercises are completed annually including unannounced drills. To ensure this deficiency does not occur again, the Safety Committee will review the training and testing requirements within the emergency preparedness plan at least annually and anytime amendments are made. Executive Director, Maintenance Director, and Safety Committee will be responsible.	02/18/2023

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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 records review with the Administrator on 12/12/22 at 10:12 a.m. and at 2:00 p.m., both required EPP exercises conducted on 04/11/22 and 04/14/22 were incomplete. A sign in sheet was provide stating a tabletop drill was conducted and an actual emergency event happened, but the forms did not indicate the scenario, what policies were used, and analyzing the facility's response. Based on interview at the time of records review, the Administrator agreed the documentation did not include the scenario, what EEP policies were used, nor analyzing the facility's response This finding was reviewed with the Maintenance Director and the Administrator during the exit conference.			
E 0041 SS=C Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and			

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	procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.			

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	*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155176	A. BUILDING -- B. WING	12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator on 12/12/22 at 10:02 a.m., the generator lacked monthly load testing and weekly inspections required by LSC and NFPA 110. Based on interview at the time of record review, the Administrator stated the generator was missing some of the required testing. The findings were reviewed with the Administrator and Maintenance Director at the exit conference.	E 0041	How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No Resident was directly affected by the deficient practice. Regional Maintenance Director/Designee will be backup if Maintenance Director not available. How will the facility identify other residents having the potential to be affected by the deficient practice: The facility recognizes that all residents, staff, and visitors have the potential of being affected by the deficient practice. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: Maintenance Director will maintain documentation in Life Safety Binder. Maintenance Director was given 1:1 education by Executive Director. How the facility will monitor its	01/07/2023

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			corrective action to ensure that the deficient practice is being corrected and not recur: Maintenance Director will document monthly and weekly generator checks and bring any identified issues to the monthly QA meeting to ensure compliance and to determine if further action is deemed necessary.	
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: 12/12/22 Facility Number: 000092 Provider Number: 155176 AIM Number: 100266090 At this Life Safety Code survey, Glenbrook Rehabilitation and Skilled Nursing Center 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 with a basement was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. Battery operated	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a post survey revisit on or after February 18, 2023.	

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	smoke detectors have been installed in the resident rooms. The facility has a capacity of 82 and had a census of 57 at the time of this survey. All areas where the residents have customary access are sprinkered. All areas providing facility services are sprinklered. Quality Review completed on 12/13/22			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 1 housekeeping storeroom doors and 1 of 2 cooler/freezer doors were able to open from the inside if locked. LSC 19.2.2.1 states doors complying with 7.2.1 shall be permitted. 7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied. This deficient practice could staff that use housekeeping supplies and the freezer. Findings include: Based on observation with the Maintenance Director and Administrator on 12/12/22 at 12:33 p.m. and 1:12 p.m., the following was observed: #1. The rear housekeeping storeroom door was locked with a padlock from the outside and there	K 0211	K-0211 #1: 1.The identified pad lock on the rear housekeeping storeroom has been removed 2.No other doors were identified as a concern. 3.Housekeeping Staff have the potential to be affected. 4.The IDT team was educated by the Executive Director that pad locks are not to be used on any doors. 5.The IDT team will check for pad locks during routine customer care rounds. Maintenance Director will report findings to QA committee for appropriate follow up for at least 6 months. If 100%	02/18/2023

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	was no release from the inside to open the door if lock with the pad lock. There was a second exit door, but it was locked with a padlock from the inside and would not unlock do to there was no key. This condition could trap a person inside the storeroom if locked from the outside. Based on interview at the time of observation, the Administrator agreed the housekeeping storeroom door was locked with a padlock and could not open from the inside when locked. #2. The walk-in freezer release handle on the inside to open the door did not work. This condition could trap a person inside the freezer when latched shut. Based on interview at the time of observation, the Maintenance Director and the Administrator agreed the freezer release handle was not working and stated the release mechanisms would need to be repaired. The findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b).		threshold is not met an action plan will be developed. K-0211 # 2: 1.The identified release handle inside the walk-in freezer was repaired to function properly 2.No other doors were identified as a concern. 3. Staff who use the walk-in freezer have the potential to be affected. 4.The Culinary Staff was educated by the Executive Director that if the emergency handle was not functioning properly at any time, to alert Executive Director/ Maintenance Director immediately 5. Maintenance Director will check functioning of handle weekly. Maintenance Director will report findings to QA committee for appropriate follow up for at least 6 months. If 100% threshold is not met an action plan will be developed.	
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING			

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	Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS			

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	LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 3 of 6 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could all residents. Findings include: Based on observation with the Administrator on 12/12/22 between 11:00 a.m. and 1:10 p.m., the posted codes to open the magicianly locked exit doors by rooms 201, 231, and the lounge had the wrong code posted. When the posted codes were entered into a keypad, the doors did not unlock. The doors did open when the correct code was entered. Based on interview at the time of observation, the Administrator stated the posted codes were incorrect to help prevent elopements.	K 0222	1.The identified access control pad codes have been posted visibly on the access control pad for all staff, residents, and visitors to see in order to exit. 2.The Executive Director has ensured that all codes posted are the correct codes to exit all identified doors via the access control pads. All residents, staff, and visitors have the potential to be affected. 3.The Maintenance Director was educated by the Executive Director on posting and updating the codes on the access control pads if the codes are changed. 4.The Maintenance Director will oversee monthly checks of access control pads for proper posting of codes and functionality. The Maintenance Director will report	01/07/2023

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	This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		findings to QA committee for appropriate follow up annually. If 100% threshold is not met an action plan will be developed.	
K 0226 SS=E Bldg. 01	NFPA 101 Horizontal Exits Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 6 horizontal exit fire door sets were arranged to automatically close and latch. LSC section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. In addition, NFPA 80, the Standard for Fire Doors and Other Opening Protectives, section 6.1.4.2.1 states self-closing doors shall swing easily and freely and shall be equipped with a closing device to cause the door to close and latch each time it is opened. This deficient could affect 30 residents in 2 smoke compartments when occupied. Findings include: Based on observations during a tour of the facility with the Administrator on 12/12/22 at 11:31 a.m., in a fire barrier by the north nurse's station the 3-hour rated fire door set was use as a horizontal exit and as a smoke barrier. When tested one of the door leaves failed to latch into the frame. Based on interview at the time of observation, the Administrator stated one of the door leaves of the fire door set did not latch into the frame when tested.	K 0226	1.The identified smoke barrier door by the north nurse's station was repaired to latch properly. 2.All smoke barrier doors have been checked to ensure proper latching. Staff and at least 30 residents have the potential to be affected. 3.The Maintenance Director was educated on K226 by the Executive Director. All other doors were examined by the Maintenance Director to ensure compliance with K226. The Maintenance Director was educated on ensuring all smoke barrier doors latch properly. Rounds were completed by the ED and the Maintenance Director to ensure that all smoke barrier doors latch properly. 4.The Maintenance Director/Designee will	02/18/2023

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	This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		make rounds daily x 4 weeks then weekly x 4 weeks then monthly for at least 6 months to ensure that all doors close and latch into the door frame. The Executive Director will monitor that rounds are completed and that all smoke barrier doors latch daily x 4 weeks then weekly x 4 weeks then monthly for at least 6 months. The results of the monitoring will be forwarded to QA committee.	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on records review and interview, the facility failed to ensure 21 of 21 battery backup lights were tested monthly. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all building occupants. Findings include: Based on records review with the Administrator on 12/12/22 at 9:39 a.m., the documentation of a monthly 30 second test for the battery powered emergency lighting showed no tests were conducted for November 2022. Based on an interview at the time of record review, the	K 0291	How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No Resident was directly affected by the deficient practice. Regional Maintenance Director/Designee will be backup if Maintenance Director not available. How will the facility identify other residents having the potential to be affected by the deficient practice: The facility recognizes that all residents, staff, and visitors have the potential of being affected by the deficient practice. What measures will be put in	01/07/2023

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	Administrator stated the testing was missed due to lack of maintenance personnel. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		place or systemic changes made to ensure that the deficient practice will not recur: Maintenance Director will maintain documentation in Life Safety Binder. Maintenance Director was given 1:1 education by Executive Director. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and not recur: Maintenance Director will document monthly emergency lighting checks and bring any identified issues to the monthly QA meeting to ensure compliance and to determine if further action is deemed necessary.	
K 0300 SS=F 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, the facility failed to ensure documentation for the preventative maintenance of 40 of 40 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. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in	K 0300	How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No Resident was directly affected by the deficient practice. Regional Maintenance Director/Designee will be backup if Maintenance Director not available.	01/07/2023

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	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 all building occupants. Findings include: Based on records review with the Administrator on 12/12/22 at 9:49 a.m., the documentation of the battery-operated smoke alarm testing showed no tests were conducted for November 2022. Based on an interview at the time of record review, the Administrator stated the testing was missed due to lack of maintenance personnel. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		How will the facility identify other residents having the potential to be affected by the deficient practice: The facility recognizes that all residents, staff, and visitors have the potential of being affected by the deficient practice. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: Maintenance Director will maintain documentation in Life Safety Binder. Maintenance Director was given 1:1 education by Executive Director. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and not recur: Maintenance Director will document monthly battery-operated smoke alarm testing checks and bring any identified issues to the monthly QA meeting to ensure compliance and to determine if further action is deemed necessary.	
K 0341 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any			

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	part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm control panel was protected. NFPA 72, National Fire Alarm and Signaling Code Section 10.10.1 states a means for turning off activated alarm notification appliance(s) shall be permitted only if it complies with 10.10.3 through 10.10.7. Section 10.10.3 states the means shall be key-operated or located within a locked cabinet or arranged to provide equivalent protection against unauthorized use. This deficient practice could affect all occupants. Findings include: Based on observation with the Administrator on 12/12/22 at 12:00 p.m., the fire control panel located at the north nurses station was in a cabinet but the door to the cabinet was unlocked when checked lock. This condition does not protect the fire alarm system against unauthorized use. Based on interview at the time of observations, the Administrator agreed the cabinet door to the fire control panel was not properly secured and did lock the door. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0341	Corrective actions were as follows: Maintenance Director was educated on K341 NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code, by Executive Director. Executive Director removed key and properly stored key to protect against unauthorized use in accordance with NFPA 70 and 72. Nursing staff educated per Maintenance Director as to location of stored key.	01/07/2023

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K 0353 SS=F 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, 7.7.7, 9.7.8, and NFPA 25 Based on record review, observations, and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5 which requires all automatic sprinkler systems to be inspected and maintained in accordance with NFPA 25. Table 5.1.1.2 indicates the required frequency of inspection and testing. Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation. This deficient practice could affect all occupants. Findings include:	K 0353	K353 #1: 1.The dry pendants for the cooler and freezer have been ordered by the outside vendor, however, parts will not arrive for more than 90 days after the survey exit date. A temporary waiver has been requested. As soon as parts arrive, outside vendor will install. 2.No other pendants are in need of replacement 3.All occupants of the facility have the potential to be affected. 4.The Maintenance Director was educated that if any sprinkler heads have been identified that they are in need of replacement, they should be replaced by vendor	04/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155176	A. BUILDING 01 B. WING	12/12/2022

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	Based on observation and records review with the Administrator on 12/12/20 between 10:00 a.m. and 1:00 p.m., the following deficiencies were found: #1. The inspection form for the sprinkler system dated 08/17/22 stated, "Total of two dry pendants in the cooler and freezer are due to be replaced." No documentation was provided to show the dry pendants were replaced. Also during observation, the dry pendants were not replaced and showed signs of corrosion. Based on an interview at the time of record review and observation, the Administrator stated the dry pendants have not been replaced #2. The inspection documentation for the gauges and valves on the sprinkler system showed no tests were conducted for November 2022. Based on an interview at the time of record review, the Administrator stated the testing was missed due to lack of maintenance personnel. #3 during observation, In the break room the deflector on the side wall sprinkler head by the door was bent down and not in the correct orientation. Based on an interview at the time of observation, the Administrator agreed the deflector was bent down and not in the correct orientation for complete coverage of the room. The findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		as soon as possible. 5.The Maintenance Director will review all sprinkler checks completed by outside vendor with Executive Director. Maintenance Director will report findings to QA committee for appropriate follow up for at least 6 months. If 100% threshold is not met an action plan will be developed. K353 # 2: How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No Resident was directly affected by the deficient practice. Regional Maintenance Director/Designee will be backup if Maintenance Director not available. How will the facility identify other residents having the potential to be affected by the deficient practice: The facility recognizes that all residents, staff, and visitors have the potential of being affected by the deficient practice. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: Maintenance Director will maintain documentation in Life Safety Binder. Maintenance Director was given 1:1 education by Executive Director.	

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			How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and not recur: Maintenance Director will document monthly sprinkler system checks and bring any identified issues to the monthly QA meeting to ensure compliance and to determine if further action is deemed necessary. K353 # 3: 1.The identified sprinkler head in the break room was corrected to be in the correct orientation 2.No other sprinkler heads are found to be in incorrect orientation. 3.All occupants of the facility have the potential to be affected. 4.The Maintenance Director will check all sprinkler heads according to TELS system. Maintenance Director will report findings to QA committee for appropriate follow up for at least 6 months. If 100% threshold is not met an action plan will be developed.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric			

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	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 1 of 2 electrical boxes in in the riser room was securely fastened in place and 1 of 10 junction boxes in the attic was provided with a cover. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70. Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Article 406.5 states receptacles shall be mounted in boxes or assemblies designed for the purpose, and such boxes or assemblies shall be securely fastened in place unless otherwise permitted elsewhere in this Code. This deficient practice could affect 15 residents in two smoke compartments. Findings include: Based on observation with the Administrator and the Maintenance Director on 12/12/22 at 11:48 a.m. and at 1:11 p.m., the following was observed: #1 In the riser room there was an electrical box hanging from the ceiling exposing wires. Based on interview at the time of observation, the Administrator agreed the box was not fasten securely and would need to be remounted. #2 In the center attic there was an electrical junction box without a cover and had exposed electrical wiring. Based on interview at the time of the observations, the Maintenance Director acknowledged the electrical junction box was not	K 0511	K511 #1: 1.The identified electrical box was remounted 2.No other electrical boxes are in need of remounting 3.15 residents have the potential to be affected. 4.The Maintenance Director will monitor all electrical boxes weekly for 4 weeks, monthly for 6 months until 100% compliance is achieved. Maintenance Director will report findings to QA committee for appropriate follow up for at least 6 months. If 100% threshold is not met an action plan will be developed. K511 #2: 1.The identified exposed electrical junction box was covered 2.No other electrical junction boxes are exposed 3. 15 residents have the potential to be affected. 4.The Maintenance Director will monitor all electrical junction boxes weekly for 4 weeks, monthly for 6 months until 100% compliance is achieved. Maintenance Director will report	01/07/2023

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	provided with a cover and had exposed wires. The findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		findings to QA committee for appropriate follow up for at least 6 months. If 100% threshold is not met an action plan will be developed.	
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 Based on record review and interview, the facility failed to conduct fire drills on each shift for 1 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. This deficient practice affects all staff and residents. Findings include: Based on records review with the Administrator on 12/12/22 at 9:32 a.m., no documentation was available to show a first shift fire drill for the third quarter of 2022 was conducted. Based on interview at the time of record review, the	K 0712	How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No Resident was directly affected by the deficient practice. Regional Maintenance Director/Designee will be backup if Maintenance Director not available. How will the facility identify other residents having the potential to be affected by the deficient practice: The facility recognizes that all residents, staff, and visitors have the potential of being affected by the deficient practice.	01/07/2023

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	Administrator stated the aforementioned drill was not conducted due to there was no Maintenance Director during that time. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)		What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: Maintenance Director will maintain documentation in Life Safety Binder. Maintenance Director was given 1:1 education by Executive Director. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and not recur: Maintenance Director will document monthly fire drills and ensure that all shifts have at least one drill completed quarterly. Maintenance Director will bring any identified issues to the monthly QA meeting to ensure compliance and to determine if further action is deemed necessary.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.			

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	(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 observation and interview; the facility failed to ensure 2 of 2 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect staff and 10 residents in the courtyard. Findings include: Based on observation with the Administrator on 12/12/22 at 11:30 a.m. and 12:23 p.m., in the courtyard resident smoking area there were over 30 cigarette butts disposed on the ground in and around the smoking area. Also, in the staff smoking area there were 25 cigarette butts disposed on the ground. Based on interview at the time of observations, the Administrator agree there were cigarette butts on the ground in the aforementioned locations. This finding was reviewed with the Administrator and Maintenance Director during the exit	K 0741	1.The identified inappropriate disposal of cigarette butts have been properly disposed of. A noncombustible container was placed in the staff smoking area. 2. All smoking residents and staff have been re educated on proper cigarette disposal. All staff have been in-serviced on the smoking policy. 3.The Maintenance Director was educated by the Executive Director that the facility staff and resident smoking areas need to be free of improperly disposed cigarette butts. Maintenance director also educated on need to make sure compliance is maintained.	01/07/2023

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	conference. 3.1-19(b)		4.The Maintenance Director will oversee the proper disposal of cigarette butts in the resident and staff smoking areas and that the areas will be free of cigarette butts. The Maintenance Director will report findings to QA committee for appropriate follow up monthly for 6 months. If 100% threshold is not met an action plan will be developed.	
K 0761 SS=E Bldg. 01	Based on observation and interview, the facility failed to maintain 2 of 2 rolling fire door in accordance with NFPA 80. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80 5.2.1 requires fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. This deficient practice could affect 25 residents in the main dining room. Findings include: Based on records review with the Administrator on 12/12/22 at 10:50 a.m., the fire door drop test dated 06/27/22 stated both windows failed drop test even after manual release. Based on observation with the Maintenance Director at 12:30 p.m., there were two rolling fire windows	K 0761	1.The identified rolling fire windows have been repaired to drop 2.No other rolling fire doors in the facility 3.Up to 25 residents in the main dining room have the potential to be affected. 4.The Maintenance Director was educated that if any equipment have been identified that they are in need of repair, they should be repaired by vendor as soon as possible. 5.The Maintenance Director will review all rolling fire door checks completed by outside vendor with Executive Director. Maintenance Director will report findings to QA committee for appropriate follow up for at least 6 months. If 100% threshold is not met an action plan will be developed.	02/18/2023

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	between the kitchen and dining room. Neither window dropped when hitting the test button and after testing the manual release. Based on interview at the time of observation and records review, the Administrator and the Maintenance Director agreed both fire windows did not work when tested and have not been repaired. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a			

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	program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 12 months and weekly inspection for 12 of 52 weeks. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Section 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator on 12/12/22 at 10:47 a.m., no documentation was available for the month of November 2022 to show the generator set in service was exercised at least	K 0918	How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No Resident was directly affected by the deficient practice. Regional Maintenance Director/Designee will be backup if Maintenance Director not available. How will the facility identify other residents having the potential to be affected by the deficient practice: The facility recognizes that all residents, staff, and visitors have the potential of being affected by the deficient practice. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: Maintenance Director will maintain documentation in Life Safety Binder. Maintenance Director was given 1:1 education by Executive Director.	01/07/2023

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	once monthly, for a minimum of 30 minutes. Also, the generator weekly inspection log showed 12 weekly inspection were missing with in the last 52 weeks. Based on an interview at the time of record review, the Administrator stated the load test and weekly tests were not conducted due to no Maintenance Director during that time. The findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and not recur: Maintenance Director will document monthly and weekly generator checks and bring any identified issues to the monthly QA meeting to ensure compliance and to determine if further action is deemed necessary.	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure.			

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	Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 12 of 12 full and empty oxygen cylinders were separated and marked to avoid confusion. NFPA 99, Section11.6.5.2 states, if empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Section 11.6.5.3 states, empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner. This deficient practice could affect up to 30 residents in one smoke compartment. Findings include: Based on observations with the Administrator on 12/12/22 at 12:35 p.m., the oxygen storage room contained full and empty oxygen cylinders, but the cylinders were mixed together and not marked as full or empty. Based on interview at the time of observation, the Administrator stated the cylinders were not marked as full and empty.	K 0923	How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No Resident was directly affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the deficient practice: The facility recognizes that up to 30 residents have the potential of being affected by the deficient practice. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: Maintenance Director will separate oxygen cylinders, filled and empty and label clearly with signs.	01/07/2023

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		Maintenance Director/Designee will educate staff on process of keeping oxygen cylinders separate in oxygen room. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and not recur: Maintenance Director will monitor oxygen room and bring any identified issues to the monthly QA meeting to ensure compliance and to determine if further action is deemed necessary.	