STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155005	A. BUILDING -- B. WING	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BEAUMONT REHABILITATION AND HEALTHCARE CENTER	1345 N MADISON AVE ANDERSON, IN 46011

(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: 07/15/24 Facility Number: 000005 Provider Number: 155005 AIM Number: 100270840 At this Emergency Preparedness survey, Beaumont Rehabilitation and Healthcare Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 200 and had a census of 122 at the time of this survey. Quality Review completed on 07/18/24	E 0000	The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Goran Prentoski	Administrator	07/30/2024

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

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	155005	A. BUILDING -- B. WING	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BEAUMONT REHABILITATION AND HEALTHCARE CENTER	1345 N MADISON AVE ANDERSON, IN 46011

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

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	the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not			

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

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

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

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

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

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

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	*[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale 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	**E039 EP Testing Requirements** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified** No resident was found to be affected by the finding. **2)How the facility identified other residents:** All residents that reside at the	08/04/2024

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	c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review of the facilities Emergency Preparedness program entitled "Emergency Preparedness Manual" on 07/15/24 at 10:55 a.m. with the Maintenance Director, an annual full-scale exercise that is community-based was available for review, but a second full-scale exercise that is community-based or an individual, facility-based functional exercise, a mock disaster drill, or 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 was not available as of the time of this survey. Based on an interview at the time of record review, the Maintenance Director advised that he had the tabletop exercise planned for an upcoming date, but as of yet had not had an opportunity to conduct the exercise. This item was discussed at the exit conference held on 07/15/24 at 2:25 p.m. with the Executive Director and the Maintenance Director present.		community have the potential to be affected by the alleged deficient practice **3) Measures put into place/ System changes:** Facility has scheduled to complete a tabletop community disaster drill by 8/4/2024. **4)How the corrective actions will be monitored:** The Maintenance Director/designee will ensure completion of a facility annual tabletop community disaster drill. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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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: 07/15/24 Facility Number: 000005 Provider Number: 155005 AIM Number: 100270840 At this Life Safety Code survey, Beaumont Rehabilitation and Healthcare 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 was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery-operated smoke detectors in the resident sleeping rooms. The facility has a capacity of 200 and had a census of 122 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 07/18/24	K 0000	The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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BEAUMONT REHABILITATION AND HEALTHCARE CENTER	1345 N MADISON AVE ANDERSON, IN 46011

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K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations made of the fire alarm control panel during a tour of the facility on 07/15/24 at 12:40 p.m. with the Maintenance Director, the time and date on the fire alarm control panel were incorrect. The display on the main fire alarm control panel indicated the date and time to be 02/14/00 at 7:22 a.m. when the actual date and time were 07/15/24 at 12:40 p.m. Based on interview at the time of observation, the Maintenance Director indicated he was unaware of the discrepancy and would contact the alarm company vendor to have the displayed date and time updated on the fire alarm control panel as soon as possible. This item was discussed at the exit conference	K 0345	**K345 Fire Alarm System-Testing and Maintenance** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified** No resident was found to be affected by the finding. **2)How the facility identified other residents:** All residents that reside at the community have the potential to be affected by the alleged deficient	08/04/2024

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	held on 07/15/24 at 2:25 p.m. with the Executive Director and the Maintenance Director present. 3.1-19(b)		practice 3) Measures put into place/ System changes: Facility has updated the fire alarm control panel to ensure the correct date & time was displayed. Fire panel is actively operating accordingly. **4)How the corrective actions will be monitored:** The Maintenance Director/designee will audit the fire panel 3 times per week to ensure proper date, time and operation. Audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.			

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	19.3.7.6, 19.3.7.8, 19.3.7.9 1) Based on observation and interview, the facility failed to ensure 1 of 4 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect as many as 44 residents, 4 staff and 2 visitors within the facility. Findings include: Based on observations made on 07/15/24 at 1:05 p.m. during a tour of the facility with the Maintenance Director, the set of smoke barrier doors on the 300 Hall nearest to Resident room #306 did not close completely when the door was tested on three separate occasions. Each time they were tested, there was a two-inch gap between the doors when closed to their fullest. Based on interview at the time of the observation, the Maintenance Director acknowledged these barrier doors did not close completely, adding that he would have the doors looked at as soon as possible. This item was discussed at the exit conference held on 07/15/24 at 2:25 p.m. with the Executive Director and the Maintenance Director present. 3.1-19(b) 2) Based on observation and interview, the facility failed to ensure 1 of 8 sets of corridor doors would close to form a smoke resistant barrier. This deficient practice could affect as many as 44 residents, 4 staff and 2 visitors within the facility.	K 0374	**K374 Subdivision of Building Spaces- Smoke Barriers.** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified** No individuals were found to be affected by the finding. **2)How the facility identified other residents:** 44 residents that reside at the community, 4 staff and 2 visitors had the potential to be affected by the alleged deficient practice **3) Measures put into place/ System changes:** Facility has ensured that all smoke doors within the facility are in good working order and close appropriately. A door closing coordinator was placed onto the doors leading to the Family Tree Dining Area. **4)How the corrective actions will be monitored:**	08/04/2024

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	Findings include: Based on observations made on 07/15/24 at 12:20 p.m. during a tour of the facility with the Maintenance Director, the set of smoke barrier doors leading to the "Family Tree Dining area" set of doors each swing in the same direction with the south door equipped with an astragal. The aforementioned door set was not equipped with a door closing coordinator to ensure the door equipped with an astragal closes last and forms a smoke resistant barrier. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned corridor door set was not equipped with a door closing coordinator to ensure the door equipped with an astragal closes last and forms a smoke resistant barrier and stated that he would have one added to the door set as soon as possible. This item was discussed at the exit conference held on 07/15/24 at 2:25 p.m. with the Executive Director and the Maintenance Director present. 3.1-19(b)		The Maintenance Director/designee will audit facility smoke doors weekly to ensure proper closing procedure. Audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
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.			

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	19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure 2 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on record review of the documentation entitled "Fire Drill Report" with the Maintenance Director on 07/15/24 at 9:50 a.m., the fire drill forms had lines for the documentation to indicate the transmission of the fire alarm signal was reached at the monitoring company. Based on the fire drills presented for review at the time of this survey, both the March 25th, 2024 and the September 20th, 2023 night shift fire drills lacked verification of the transmission of the fire alarm signal at the monitoring company. Based on an interview at the time of record review, the Maintenance Director advices that he was unaware he forgot to document this item and stated that he would be more dilligent in the future with documenting this item on the fire drill report form. This item was discussed at the exit conference held on 07/15/24 at 2:25 p.m. with the Executive Director and the Maintenance Director present. 3.1-19(b) 3.1-51(c)	K 0712	**K712 Fire Drills** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified** No individuals were found to be affected by the finding. **2)How the facility identified other residents:** All individuals had the potential to be affected by the alleged deficient practice **3) Measures put into place/ System changes:** Facility has ensured verification of transmission of the fire alarm signal to the monitoring station with the monitoring company. **4)How the corrective actions will be monitored:** The Maintenance Director/designee will ensure documentation and verification of fire alarm signal transmission to the monitoring system during	08/04/2024

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			routinely scheduled fire drills. Documentation from these drills will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, 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			

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	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 cigarette butts were properly disposed of at 1 of 1 areas where cigarettes were smoked. This deficient practice could affect as many as 12 residents, 4 staff and 2 visitors while at the outside smoking area. Findings include: Based on observations made on 07/15/24 at 1:20 p.m. during a tour of the facility with the Maintenance Director, the smoking area had a metallic cigarette butt container with a lid on it. When the container was opened, there were not only cigarette butts in the container, but there was also Styrofoam cups, paper napkins, and empty cigarette boxes were intermingled inside it. Based on an interview at the time of the observation the Maintenance Director agreed that there were cigarette butts in the container mixed in with combustible trash, adding that he would take care of this as soon as possible. This item was discussed at the exit conference held on 07/15/24 at 2:25 p.m. with the Executive Director and the Maintenance Director present. 3.1-19(b)	K 0741	**K741 Smoking Regulations** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified** No individuals were found to be affected by the finding. **2)How the facility identified other residents:** 12 residents that reside at the community, 4 staff and 2 visitors had the potential to be affected by the alleged deficient practice **3) Measures put into place/ System changes:** The facility has ensured removal of any trash from the cigarette disposal containers. Staff re-education was initiated. **4)How the corrective actions will be monitored:** The Maintenance	08/04/2024

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			Director/designee will audit the smoking areas to ensure cigarette disposal containers are free from unnecessary trash 5 times per week. Documentation from these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was			

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	installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 Marketing office was not using flexible cords as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect as many as 24 residents, 4 staff, and 2 visitors. Findings include: Based on observations made on 07/15/24 at 11:14 a.m. to 2:16 p.m. during a tour of the facility with the Maintenance Director, the following was noticed: a) at 11:50 a.m. the Marketing office had a power strip with a mini fridge and a microwave oven plugged into it b) at 12:10 p.m. the Assistant Director of Nursing's office had a power strip with a mini fridge plugged into it Based on interview at the time of each observation, the Maintenance Director acknowledged each use of a power strip adding that staff is aware power strip usage is not allowed but that it seemed an in-service would need to be held as a reminder of this. This item was discussed at the exit conference held on 07/15/24 at 2:25 p.m. with the Executive Director and the Maintenance Director present. 3.1-19(b)	K 0920	**K920 Electrical Equipment-Power Cord and Extension Cords** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified** No individuals were found to be affected by the finding. **2)How the facility identified other residents:** All residents have the potential to be affected by this finding. **3) Measures put into place/ System changes:** Marketing office Power Cord was removed. Assistant Director of Nursing's power strip was removed. An entire house audit was completed to ensure no non-approved power cords were present. Any located were either	08/04/2024

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			removed or replaced with hospital grade power cords. **4)How the corrective actions will be monitored:** The Maintenance Director/designee will audit 5 random areas 3 times per week to ensure no non-hospital grade power extension cords are present. Documentation from these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	