STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155690	A. BUILDING -- B. WING	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF ANDERSON	1821 LINDBERG RD ANDERSON, IN 46012

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/01/23 Facility Number: 000027 Provider Number: 155690 AIM Number: 100266180 At this Emergency Preparedness survey, Envive of Anderson 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 97 and had a census of 47 at the time of this survey. Quality Review completed on 08/09/23	E 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Emergency Preparedness and Life Safety Survey conducted August 1, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of September 8, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
E 0007 SS=F Bldg. --	403.748(a)(3), 416.54(a)(3), 418.113(a)(3), 441.184(a)(3), 482.15(a)(3), 483.475(a)(3), 483.73(a)(3), 484.102(a)(3), 485.625(a)(3), 485.68(a)(3), 485.727(a)(3), 485.920(a)(3), 491.12(a)(3), 494.62(a)(3) EP Program Patient Population §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] Based on record review and interview, the facility failed to ensure the emergency preparedness plan addressed resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans in accordance with 42 CFR 483.73(a)(3). This deficient practice could affect all occupants.	E 0007	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *All residents had the potential to be affected, however no residents were affected. The resident population information has been included in the emergency*	09/08/2023

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	Findings include: During record review with the Director of Facilities (DF) at 10:30 a.m. on 08/01/23, no documentation could be found ensuring the emergency preparedness plan addressed resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. Based on interview at the time of record review, the DF stated the policies regarding the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans could not be found. This finding was reviewed with the Administrator and DF at the exit conference. 3.1-19(b)		*preparedness plan.* **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** *All residents had the potential to be affected, however no residents were affected. The resident population information has been included in the emergency preparedness plan.* **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** *The IDT will review the Emergency Preparedness Plan at least quarterly and on-going, to ensure that all requirements are met.* **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** *The Executive Director will present the Emergency Preparedness Plan at least quarterly, at the monthly QAPI meeting for review to ensure all requirements are met.*	
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),			

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

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

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

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

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	*[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises			

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

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

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

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	problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.	E 0039	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *A facility event that occurred on 7/29/2023, has been added to the Emergency Preparedness Plan Binder.* **2: How other residents having**	09/08/2023

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	b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Director of Facilities (DF) on 08/01/23 at 12:10 p.m., documentation of a facility based annual exercise completed on 09/12/22 was available for review. Based on interview at the time of records review, the DF stated the facility completed one facility based exercise within the last 12 months. There was no documentation provided of a second exercise. This finding was reviewed with the Administrator and DF at the exit conference.		**the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** *All residents had the potential to be affected, however no residents were affected. The facility event occurring 7/29/2023 has been added to the Emergency Preparedness Plan Binder.* **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** *The IDT will review the Emergency Preparedness Plan at least quarterly on-going, to ensure all requirements are met.* **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** *The Executive Director will present the Emergency Preparedness Plan at least quarterly, at the monthly QAPI meeting for review to ensure all requirements are met.*	

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	155690	A. BUILDING -- B. WING	08/01/2023

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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: 08/01/2023 Facility Number: 000027 Provider Number: 155690 AIM Number: 100266180 At this Life Safety Code survey, Envive of Anderson 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 V111 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 powered smoke detection in the 500 and 600 hall resident sleeping rooms. The facility has a capacity of 97 and had a census of 47 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 08/09/23	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Emergency Preparedness and Life Safety Survey conducted August 1, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of September 8, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0100 SS=E	NFPA 101 General Requirements - Other			

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Bldg. 01	General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General 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 observation and interview, the facility failed to maintain latching hardware on 2 of 2 smoke barrier doors. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect staff and up to 30 residents. Findings include: Based on observation with the Director of Facilities (DF) on 08/01/23 at 12:35 p.m. and 12:50 p.m., the set of smoke barrier doors to the 300 Hall and by the Therapy room were provided with latching hardware but failed to close and latch when tested. Based on interview at the time of observation, the DF agreed the smoke doors were equipped with latching devices, but the doors did not properly close and latch when tested. The finding was reviewed with the Administrator and DF during the exit conference. 3.1-19(b)	K 0100	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *The smoke barrier doors to the 300 Hall have been adjusted to close and latch.* **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** *All residents had the potential to be affected, however no residents were affected. All smoke barrier doors have been reviewed to ensure proper closure and adjustments have been made where warranted.* **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** *The Maintenance Director or designee will check for proper closure and latch of all smoke barrier doors monthly, ongoing. Any doors found to not close, and*	09/08/2023

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			latch properly will be immediately adjusted, if an outside vendor is needed for any concerns the Maintenance Director will notify the Executive Director immediately. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** *The Maintenance Director or designee will utilize the facility TELS system to monitor smoke barrier doors and will report monthly to the QAPI Committee any findings.*	
K 0271 SS=F Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure all exit discharges around the facility had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect all residents and staff when exiting the facility. Findings include:	K 0271	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *The sidewalk is scheduled for repairs. A waiver for extension to resurface pathway is being submitted. Low hanging limbs have been removed.*	11/30/2023

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	Based on observations and interview during a tour of the facility with the Director of Facilities (DF) on 08/01/23 at 01:00 p.m., immediately outside the (1) TV Lounge Exit and (2) 500 Hall exit, a concrete pad and sidewalk terminated onto a blacktopped path which leads both directions around the facility providing exit discharge to the public way parking lots. Where the concrete sidewalks meet the blacktop pathways there is an uneven surface which could be a trip hazard. Additionally, the aforementioned blacktop pathways were cracked, broken, uneven, and in places, narrowed, creating trip hazards and obstacles during an evacuation. There were tree limbs hanging down and obstructing the path by the smoke shack. The DF said that he was unaware of the tree limb obstacle and will have the them trimmed to clear the pathway.The DF stated that they have been attempting to correct the blacktop pathways, but finding a contractor to replace it has been difficult. He acknowledged that the blacktop walkways were in need of repair to have a complete level walking surface that was free of obstructions leading to the public way. This finding was acknowledged by the Administrator and the DF at the exit conference. 3.1-19(b)		**2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** *All residents that use the sidewalk had the potential to be affected, however no residents were affected.* **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** *The Maintenance Director or designee will audit the pathway for obstructions monthly, to ensure a clear egress, ongoing.* **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** *The Maintenance Director or designee will utilize the facility TELS system to monitor facility egress and will report monthly to the QAPI Committee any findings.*	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system			

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	option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor doors to 2 of 10 rooms which is a hazardous area containing combustible storage and greater than 50 square feet was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could 20 residents in the corridor by laundry and the oxygen storage area. Findings include: Based on observations during a tour of the facility with the Director of Facilities (DF) on 08/01/23 at	K 0321	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *The doors to the laundry and oxygen storage room have had the self-closing device adjusted to ensure that the door latches properly within the door frame.* **2: How other residents having the potential to be affected by the same deficient practice will**	09/08/2023

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	02:30 p.m. and 02:55 p.m. , the laundry room, a hazardous storage room that was greater than 50 square feet and the oxygen storage room, were equipped with a self-closing device but did not latch into the frame when tested. Based on interview at the time of observation, the DF agreed that when tested, the laundry room which was larger than 50 square feet and the oxygen storage room is a hazardous area, each with a self-closing device on the door did not latch into the frame. These findings were reviewed with the Administrator and DF at the exit conference. 3.1-19(b)		**be identified and what corrective action will be taken.** *An audit was conducted, and no other areas were identified.* **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** *The Maintenance Director or designee will conduct monthly audits of all self-closing devices to ensure they are in proper working order so that the door latches properly into the frame, ongoing.* **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** *The Maintenance Director or designee will utilize the facility TELS system to monitor self-closing devices and will report monthly to the QAPI Committee any findings.*	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2,			

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	19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchen. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect staff in the kitchen and 25 residents in the dining room. Findings include: Based on observation with the Director of Facilities (DF) on 08/01/23 at 02:10 p.m., the kitchen contained a UL 300 hood system and a K-class fire extinguisher with posted instructions. Based on interview, the Cook was asked; what is the correct response if there was a grease fire underneath the hood. The employee replied; use the fire extinguisher on it. The employee failed to indicate activating the UL 300 hood extinguishing system and using the correct fire extinguisher for a hood grease fire. The DF acknowledged the Cooks response and educated the cook on the proper procedure.	K 0324	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *Dietary staff were immediately inserviced regarding the ansul system and the K-class fire extinguisher. All staff were inserviced on the Ansul System, K-class fire extinguisher, ABC extinguishers and pull station activation on 8.2.2023.* **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** *All residents have the potential to be affected, however no residents were affected.* **3: What measures will be put into place or what systemic changes will be made to**	09/08/2023

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	This finding was reviewed with the Administrator and DF at the exit conference. 3.1-19(b)		**ensure that the deficient practice does not recur?** *Fire Safety has been added to the general orientation for all staff, ongoing.* **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** *The facility will review Fire Safety during All Staff Meetings for the next 6 months, while continuing to conduct random audits of employee knowledge. The results of the training / audits will be reviewed monthly for 6 months by the QAPI committee. If substantial compliance is achieved the audits may be lessened or removed by recommendation of the committee.*	
K 0341 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire 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			

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	transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation of the fire alarm control panel with the Director of Facilities (DF) on 08/01/23 at 02:20 p.m., the time on the display of the fire alarm control panel indicated the time to be 0503 a.m. when checked at 02:20 p.m. and the date shown was 01/04/00 on 08/01/23 Based on interview at the time of observation, the DF agreed the fire alarm control panel had the wrong date and time and will need to be changed. The DF stated there was a power outage a few days earlier and probably caused this to happen. The finding was reviewed with the Administrator and DF during the exit conference. 3.1-19(b)	K 0341	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *The fire panel date and time was reset.* **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** *All residents have the potential to be affected, however no residents were affected. The Maintenance Director has been educated in how to reset the date/time on the control if necessary.* **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** *The Maintenance Director or designee will complete an audit at least monthly during the scheduled fire drill, and/or after any loss of power to ensure the fire panel has the correct date and time. Any concerns will be noted in the fire drill documentation and immediately corrected.* **4: How the corrective action will be monitored to ensure the**	09/08/2023

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			deficient practice will not recur i.e., what quality assurance program will be put into place? *The results of the Monthly audits will be reviewed by the QAPI committee monthly, on-going.*	
K 0345 SS=F 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 record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all occupants. Findings include: Based on record review with the Director of Facilities (DF) on 08/01/23 at 10:30 a.m. the Annual Fire Alarm Report from their vendor, dated 06/22/23, stated deficiencies of a broken pull station #1 and 3 smoke detectors covered with tape but there was no documentation of the pull	K 0345	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *Pull Station #1 has been repaired and the three smoke detectors have had the tape removed.* **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** *All residents had the potential to be affected, however no residents were affected.* **3: What measures will be put**	09/08/2023

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	station being repaired or the tape removed. Based on interview at the time of observation, the DF confirmed the issues but was unable to provide documentation of repair. There were 2 smoke detectors found during the facility tour that were covered with tape. Maintenance removed the tape at the time of observation. This finding was reviewed with the Administrator and DF during the exit conference. 3.1-19(b)		**into place or what systemic changes will be made to ensure that the deficient practice does not recur?** *The Maintenance Director or designee will complete monthly audits of all smoke detectors and pull stations, ongoing.* **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** *The Maintenance Director or designee will utilize the facility TELS system to monitor pull stations and smoke detectors and will report monthly to the QAPI Committee any findings.*	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on			

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	coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler head by room 210 room were free of paint accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff and up to 4 residents in two rooms. Findings include: Based on observation with the Director of Facilities (DF) on 08/01/23 at 12:55 p.m., the sprinkler head by room 210 had paint on it. Based on interview at the time of observation, the DF confirmed the sprinkler head by room 210 had paint on the it. This finding was reviewed with the Administrator and DF during the exit conference. 3.1-19(b)	K 0353	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *The sprinkler head by room 210 is scheduled to be repaired or replaced.* **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** *All residents had the potential to be affected, however no residents were affected.* **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** *Education has been provided to the Maintenance Director regarding keeping sprinkler heads free of any debris. The Maintenance Director will monitor all painting projects to ensure any paint that gets on the sprinkler head is removed immediately.* **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance**	09/08/2023

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			program will be put into place? *The Maintenance Director or designee will utilize the facility TELS system to sprinkler heads and will report monthly to the QAPI Committee any findings. The Maintenance Director will report any sprinkler heads with paint on them to the ED who will arrange for prompt repair or replacement.*	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to inspect 3 of 15 portable fire extinguishers each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers	K 0355	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *All fire extinguishers were inspected, and inspection tags updated.* **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** *All residents had the potential to be affected, however no residents were affected.* **3: What measures will be put into place or what systemic**	09/08/2023

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	using push to-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect 20 residents in the facility Findings include: Based on observation during a tour of the facility with the Director of Facilities (DF) on 08/01/23 between 1:05 p.m. and 2:25 p.m., the monthly inspection tag on the fire extinguisher located in the smoke shack (resident smoking area) lacked documentation of a monthly inspections for July 2023. The monthly inspection tag on the fire extinguisher at the employee smoking area lacked documentation of a monthly inspection for June and July 2023 and the fire extinguisher in the Activities office lacked documentation of a monthly inspection so far this year. Based on interview at the time of observation, the DF confirmed the fire extinguishers mentioned were missing the stated monthly visual inspections. These findings were reviewed with the Administrator and DF at the exit conference.		**changes will be made to ensure that the deficient practice does not recur?** *The Maintenance Director or designee will inspect and document the inspection of all fire extinguishers Monthly, ongoing.* **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** *The Maintenance Director or designee will utilize the facility TELS system to monitor fire extinguisher inspections and will report monthly to the QAPI Committee any findings.*	

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	3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.			

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	19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of 1 corridor door was provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 4 residents in the area of the wound supply room. Findings include: Based on observation with the Director of Facilities on 08/01/23 at 1:15 p.m., the corridor door to the wound supply room would not close into the frame when tested. Based on interview at the time of observation, the DF stated the corridor door would not close into the door frame because tape was covering the opening in the door latch. The tape was removed at the time of observation. The finding was reviewed with the Administrator and DF during the exit conference. 3.1-19(b)	K 0363	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *The tape was removed from the wound supply door to ensure proper closing and latching.* **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** *All residents had the potential to be affected, no other residents were affected. All doors have been inspected to ensure they are free of any impediment to closing.* **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** *The Maintenance Director or designee will complete a monthly audit to ensure that all doors are free of any impediment to closing, ongoing.* **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance**	09/08/2023

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			program will be put into place? *The Maintenance Director or designee will utilize the facility TELS system to monitor all doors are free of any impediment and close and latch properly. The results will be reported monthly to the QAPI Committee.*	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 2 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens	K 0511	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *The identified receptacles have been replaced with proper GFCI receptacles.* **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** *All residents have the potential to be affected, however no residents were affected. All receptacles have been inspected to ensure they are the proper type for their proximity to a water source.*	09/08/2023

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	(3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of		**3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** *An audit was conducted of all receptacles to ensure all receptacles within three feet of a water source were equipped with the proper GFCI receptacle. The Maintenance Director or designee will oversee the repair or replacement of all receptacles to ensure the right type is in place.* **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** *The Maintenance Director or designee will utilize the facility TELS system to monitor receptacles for correct type and will report monthly to the QAPI Committee any findings.*	

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	the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff and visitors while at the hand washing sink in the restroom and staff and residents in therapy using the sink. Findings include: Based on observation on 08/01/23 at 12:35 p.m. and 12:45 p.m. during a tour of the facility with the DF, there was one electric receptacle within three feet of the hand washing sink at the 200 Hall restroom and one electrical receptacle within 3 feet of a sink in Therapy . The two electric receptacles were not provided with ground fault circuit interrupters (GFCI). This was confirmed when tested with a GFCI tester at the time of observation. This finding was reviewed with the Administrator and DF at the exit conference. 3.1-19(b)			
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no			

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	smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 1. Based on observation and interview; the facility failed to ensure 2 of 3 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 in the smoking areas and 10 residents in the smoking exit areas. Findings include: Based on observation during a tour of the facility with the Director of Facilities (DF) on 08/01/23 at 01:40 p.m. and 02:10 p.m., in the two back employee smoking areas there were over 30 cigarette butts disposed on the ground in and around the smoking area. Based on interview at the time of observations, the DF agreed there were cigarette butts on the ground in the aforementioned locations. 2. Based on observation and interview; the facility	K 0741	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *All staff were inserviced on the smoking policy on 8.2.2023.* **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** *All residents had the potential to be affected, however no residents were affected.* **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient**	09/08/2023

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	failed to ensure 1 of 3 smoking areas were maintained by disposing cigarette butts in the provided metal or noncombustible containers with self-closing cover devices. This deficient practice could affect staff in the smoking area and 5 residents in the smoking exit area. Findings include: Based on observation during a tour of the facility with DF on 08/01/23 at 01:40 p.m., In the staff smoking area outside the 500 hall exit there were over 20 cigarette butts disposed in a trash can containing combustible materials. Based on interview at the time of observation, the DF agreed the cigarette butts were in a trash can along with trash. These findings was reviewed with the Administrator and DF during the exit conference. 3.1-19(b)		**practice does not recur?** All staff were inserviced on the smoking policy which includes the proper disposal of cigarette butts. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Maintenance Director or designee will make daily rounds of all smoking areas and look for and properly dispose of any cigarette butts. The maintenance Director will present his findings to the IDT during the morning meeting. Positive findings will result in additional staff inservicing.	
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less			

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	than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility failed to ensure trash receptacles in 1 of 1 corridors were maintained in accordance with 19.7.5.7. This deficient practice could affect staff and up to 10 residents in the 100-hall. Findings include: Based on observations during a tour of the facility with the Director of Facilities (DF) on 08/01/23 at 12:20 p.m., there was a soiled linen/trash barrel side by side cart over 32 gallon total capacity in the corridor on the 100-hall that was not attended. Based on interview at the time of observation, the DF stated that he did not know the capacity of the soiled linen/trash cart but agreed it was not attended. The finding was reviewed with the Administrator and the DF during the exit conference. 3.1-19(b)	K 0754	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *The soiled linen/trash cart has been stored in a proper location.* **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** *All residents had the potential to be affected, however no residents were affected.* **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** *All staff were inserviced about the proper usage and storage of the soiled linen/trash cart.* **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** *The Executive Director or designee will audit weekly for the proper storage of soiled linen/trash cart for 6 months. The results of*	09/08/2023

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			the audit will be presented monthly to QAPI Committee, once substantial compliance has been achieved the QAPI Committee may discontinue the audit.	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and interview, the facility failed to ensure non-hospital grade electrical receptacles at resident sleeping rooms were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as	K 0914	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *Annual receptacle testing will be*	09/08/2023

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	hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on observations during a tour of the facility with the Director of Facilities (DF) on 08/01/23 between 12:20 p.m. and 3:35 p.m., the facility's resident sleeping rooms contained four to eight non-hospital-grade electrical receptacles. Based on records review at 11:30 a.m., documentation was available to show the last time the electrical receptacles in resident sleeping rooms were tested but it lacked a date or inspector name. Based on interview at the time of the observation and records review, the DF confirmed all the electrical receptacles in the resident sleeping rooms were not hospital-grade and stated it is unknown the last time the annual testing was completed because there is no date on the documentation provided. This finding was reviewed with the Administrator and DF during the exit conference. 3.1-19(b)		*conducted and properly documented, for all receptacles throughout the facility.* **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** *All residents had the potential to be affected, however no residents were affected. Annual receptacle testing will be conducted.* **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** *The Maintenance Director or designee will conduct annual receptacle testing and utilize the TELS system to document the testing, on-going.* **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** *The Maintenance Director or designee will utilize the facility TELS system to monitor receptacle testing and will report monthly to the QAPI Committee any findings.*	

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	155690	A. BUILDING 01 B. WING	08/01/2023

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K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 power strip was not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 5 residents in the housekeeping supervisor office area. Findings include:	K 0920	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *The plug in was relocated to allow the refrigerator to be directly plugged into the wall receptacle. The power strip was removed.* **2: How other residents having the potential to be affected by**	09/08/2023

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	Based on observations during a tour of the facility with the Director of Facilities (DF) on 08/01/23 at 02:30 p.m., a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in the housekeeping supervisor's office. Based on interview at the time of observation, the DF acknowledged a power strip was supplying power to high power draw equipment. This power strip was powered by a receptacle in the next room. There was a one inch hole drilled through the drywall and the power strip cord was ran through it. This finding was reviewed with the Administrator and DF at the exit conference, 3.1-19(b)		**the same deficient practice will be identified and what corrective action will be taken.** *All residents had the potential to be affected, however no residents were affected. An audit was conducted to ensure that any power strip in use was the correct type and used in a proper manner.* **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** *All staff were inserviced regarding the proper usage of properly rated power strips, and that high current draw items, (i.e., appliances, beds, medical equipment) must be directly plugged into the wall receptacle.* **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** *The Maintenance Director or designee will complete a monthly audit ongoing in regard to power strips and high current draw items. The results of the audit will be provided to the QAPI Committee monthly, until substantial compliance has been achieved.*	
K 0923 SS=E	NFPA 101 Gas Equipment - Cylinder and Container			

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Bldg. 01	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. 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.			

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	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 1 of 1 liquid oxygen containers was secured against unauthorized access. NFPA 99, Section 11.3.2.1 states storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. This deficient practice could affect any resident, staff or visitor in the vicinity of 100 Hall. Findings include: Based on observation on 08/01/23 during the tour of the facility with the Director of Facilities (DF) at 09:15 a.m., an oxygen tank used for transfilling portable oxygen cannisters was located in the 100 Hall corridor. Based on interview at the time of observation, the DF acknowledged the oxygen tank was located in the corridor, unsecured but did not know why it was there. At the final inspection of the day it was observed that the oxygen tank was no longer in the 100 Hall corridor. This finding was reviewed with the Administrator DF at the exit conference. 3.1-19(b)	K 0923	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *The oxygen container was being exchanged and was removed after replacing it with a new cylinder.* **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** *All residents had the potential to be affected, however no residents were affected.* **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** *All staff were inserviced regarding the proper securing and storage of oxygen.* **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** *The Maintenance Director or designee will audit the storage of oxygen containers weekly for 6 months, and report to the QAPI Committee. Once substantial compliance has been achieved*	09/09/2023

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			the QAPI Committee may remove the audit.	