STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155441	A. BUILDING -- B. WING	09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORYDON NURSING AND REHABILITATION CENTER	315 COUNTRY CLUB RD CORYDON, IN 47112

(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 State Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/11/18 Facility Number: 000338 Provider Number: 155441 AIM Number: 100287590 At this Emergency Preparedness survey, Corydon Nursing and Rehabilitation Center was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 38 certified beds. At the time of the survey, the census was 27. Quality Review completed on 09/17/18 - DA The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0023 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records in accordance with 42 CFR 483.73(b)(4). This deficient practice could affect all occupants.	E 0023	E 023 Policies and Procedures for Medical Documentation o What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; o All Residents have the chance to affected by the deficient	10/11/2018

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

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	Findings include: Based on record review with the Administrator and the Maintenance Director on 09/11/18 at 10:20 a.m., a policies and procedure that included a system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records was not available for review. Based on interview at the time of record review then again at the exit conference, the Administrator and the Maintenance Director confirmed the facility does have a system of medical documentation but no policy and procedure was available for review.		practice. o How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the practice o All residents have the potential to be affected by the practice o The plan will be updated by 10/11/2018 to address medical documentation that preserves and protect patient information and confidentiality. o What measures will be into place or what systemic changes will be made to ensure that the deficient practice does not occur; o Emergency preparedness training will be provided for staff at least annually on 10/10/2018. o Documentation will be maintained of all emergency preparedness training. Initial emergency preparedness training will be provided during general orientation, and volunteer orientation, when applicable. o Facility staff will participate in a community-based exercise at least annually if accessible.	

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			o How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place o QA program will be put into place ED/or designee will review Emergency preparedness program with QAPI team annually to ensure compliance. o By what date the systemic changes will be complete o 10/11/2018 o Facility requests desk review in lieu of revisit	
E 0024 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Administrator and the Maintenance Director on 09/11/18 at 10:21 a.m., a policy and procedure that included the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or	E 0024	E 024 Policies/Procedures – Volunteers and Staffing o What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; o All residents have the potential to be affected o The plan will be updated by 10/11/2018 to include to interrogation of state and federal health care professional to address surge needs. o How other residents having the potential to be affected by the same deficient practice will be	10/11/2018

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	Federally designated health care professionals to address surge needs during an emergency was not available for review.		identified and what corrective action(s) will be take; o All residents and staff have the potential to affected. o The plan will be updated by 10/11/2018 to include to interrogation of state and federal health care professional to address surge needs. o What measures will be into place or what systemic changes will be made to ensure that the deficient practice does not occur; o Emergency preparedness training will be provided for staff at least annually on 10/10/2018. Documentation will be maintained of all emergency preparedness training. o Initial emergency preparedness training will be provided during general orientation, and volunteer orientation, when applicable. o Emergency preparedness facility exercises and/or drills will be conducted based on the emergency plan and risk assessment. o Facility staff will participate in a community-based exercise at least annually if accessible o Documentation of the training will be maintained in the employee file, within in-service binder and/or in computer-based system. o How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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			program will be put into place o QA program will be put into place ED/or designee will review Emergency preparedness program with QAPI team annually to ensure compliance. o By what date the systemic changes will be completed o 10/11/2018 o Facility requests desk review in lieu of revisit	
E 0026 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.73(b)(8). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator and the Maintenance Director on 09/11/18 at 10:24 a.m., a policy and procedure for the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act was not available for review. Based on interview at the time of record review then again at the exit conference, the Administrator and the Maintenance Director confirmed he was unaware of the regulation and that no policy and procedure was available for review.	E 0026	E 026 Roles Under a Waiver Declared by Secretary o What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; o All resident has the potential to be affected by this practice. o The plan will be updated by 10/11/2018 to include emergency preparedness policies alternate care site and reviewed annually and updated. o How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; o All resident has the potential to be affected by this practice. o The plan will be updated by	10/11/2018

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			10/11/2018 to include emergency preparedness policies alternate care site and reviewed annually and updated. o What measures will be into place or what systemic changes will be made to ensure that the deficient practice does not occur; o Emergency preparedness training will be provided for staff at least annually. o Documentation will be maintained of all emergency preparedness training. o Initial emergency preparedness training will be provided during general orientation, and volunteer orientation, when applicable. o Emergency preparedness facility exercises and/or drills will be conducted based on the emergency plan and risk assessment. o Facility staff will participate in a community-based exercise at least annually if accessible. o Documentation of the training will be maintained in the employee file, within in-service binder and/or in computer-based system. o How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place o QA program will be put into	

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			place ED/or designee will review Emergency preparedness program with QAPI team annually to ensure compliance. o By what date the systemic changes will be completed o 10/11/2018 o Facility requests desk review in lieu of revisit	
E 0032 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (3) Primary and alternate means for communicating with the following: (i) LTC facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies in accordance with 42 CFR 483.73(c)(3). This deficient practice could affect all occupants. Finding include: Based on record review with the Administrator and the Maintenance Director on 09/11/18 at 10:27 p.m., the emergency preparedness communication plan failed to include a primary and an alternate means for communication. Based on interview at the time of record review then again at the exit conference, the Administrator and the Maintenance Director confirmed the facility does not have a written plan for primary and alternative means for communication.	E 0032	E 032 Primary/Alternate Means for Communication o What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; o All resident has the potential to be affected by this practice o The plan will be updated on 10/11/2018 to include Communication plan, LTC staff, federal, tribal, regional and local emergency management. o How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; o All resident has the potential to be affected by this practice. o The plan will be updated by 10/11/2018 to include emergency	10/11/2018

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			preparedness policies alternate care site and reviewed annually and updated. o What measures will be into place or what systemic changes will be made to ensure that the deficient practice does not occur; o Emergency preparedness training will be provided for staff at least annually. o Documentation will be maintained of all emergency preparedness training. o Initial emergency preparedness training will be provided during general orientation, and volunteer orientation, when applicable. o Emergency preparedness facility exercises and/or drills will be conducted based on the emergency plan and risk assessment. o Facility staff will participate in a community-based exercise at least annually if accessible. o Documentation of the training will be maintained in the employee file, within in-service binder and/or in computer-based system o How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place o QA program will be put into place ED/or designee will review	

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			Emergency preparedness program with QAPI team annually to ensure compliance. o By what date the systemic changes will be completed o 10/11/2018 o Facility requests desk review in lieu of revisit	
E 0033 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (4) A method for sharing information and medical documentation for residents under the LTC facility's care, as necessary, with other health care providers to maintain the continuity of care; (5) A means, in the event of an evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); (6) A means of providing information about the general condition and location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4) in accordance with 42 CFR 483.73(c)(4). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator and the Maintenance Director on 09/11/18 at 10:28 a.m., the emergency preparedness plan failed to include a communication plan that included a method for sharing information and medical documentation for residents under the LTC	E 0033	E 033 Methods for Sharing Information o What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; o All resident has the potential to be affected by this practice. o The plan will be updated by 10/11/2018 to include a method of sharing information and medical documentation with other healthcare providers. And a way to provide general information about general condition and location of residents. o Our providers utilize point click care o How other residents having the potential to be affected by the same deficient practice will be	10/11/2018

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	facility's care, as necessary, with other health care providers to maintain the continuity of care. Based on interview at the time of record review, the Administrator and the Maintenance Director confirmed no further documentation was available for review.		identified and what corrective action(s) will be taken; o All resident has the potential to be affected by this practice o The plan will be updated on 10/11/2018 to include a method of sharing information and medical documentation with other healthcare providers. And a way to provide general information about general condition and location of residents. o o What measures will be into place or what systemic changes will be made to ensure that the deficient practice does not occur; o Emergency preparedness training will be provided for staff at least annually 10/10/2018. o Documentation will be maintained of all emergency preparedness training. o Initial emergency preparedness training will be provided during general orientation, and volunteer orientation, when applicable. o Emergency preparedness facility exercises and/or drills will be conducted based on the emergency plan and risk assessment. o Facility staff will participate in a community-based exercise at least annually if accessible. o Documentation of the training will be maintained in the employee file, within in-service binder and/or in computer-based system.	

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			o How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place o QA program will be put into place ED/or designee will review Emergency preparedness program with QAPI team annually to ensure compliance. o By what date the systemic changes will be completed o 10/11/2018 o Facility requests desk review in lieu of revisit	
E 0034 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.73(c)(7). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator and the Maintenance Director on 09/11/18 at 10:32	E 0034	E 034 Information on Occupancy/Needs o What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; o All resident has the potential to be affected by this practice. o The plan will be updated by 10/11/2018 to include information about facility occupancy, needs and ability to aid.	10/11/2018

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	a.m., a communication plan that included a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.73(c)(7) was not available for review. Based on interview at the time of record review then again at the exit conference, the Administrator and the Maintenance Director confirmed that the communication plan did not include the aforementioned occupancy, needs, and ability to provide assistance to the AHJ, IC, or designee.		o How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; o All resident has the potential to be affected by this practice. o The plan will be updated by 10/11/2018 to include information about facility occupancy, needs and ability to aid. o What measures will be into place or what systemic changes will be made to ensure that the deficient practice does not occur; o Emergency preparedness training will be provided for staff at least annually on 10/10/2018. o Documentation will be maintained of all emergency preparedness training. Initial emergency preparedness training will be provided during general orientation, and volunteer orientation, when applicable. o Emergency preparedness facility exercises and/or drills will be conducted based on the emergency plan and risk assessment. o Facility staff will participate in a community-based exercise at least annually if accessible. o Documentation of the training will be maintained in the employee file, within in-service binder and/or in computer-based system.	

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			o o How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place o QA program will be put into place ED/or designee will review Emergency preparedness program with QAPI team annually to ensure compliance. o By what date the systemic changes will be completed o 10/11/2018 o Facility requests desk review in lieu of revisit	
E 0035 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator and the Maintenance Director on 09/11/18 at 10:33 a.m., the emergency preparedness communication	E 0035	E 035 LTC and ICF/IID Sharing Plan with Patients o What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; o The facility has a method for sharing information from emergency plan with residents and their families or representatives. o We will discuss during Care Plans	10/11/2018

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	plan failed to include a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). Based on interview at the time of record review, the Administrator and the Maintenance Director confirmed that no documentation or plan has been created or shared.		o We will discuss and go over for all new admissions o How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; o All residents have the potential to be affected by this finding. o The facility has a method for sharing information from emergency plan with residents and their families or representatives. o We will discuss during Care Plans o We will discuss and go over for all new admissions o What measures will be into place or what systemic changes will be made to ensure that the deficient practice does not occur o The policy will be located in the Emergency Preparedness program binder under communication plan. o How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place o The policy is in the Emergency Preparedness program binder under communication plan.	

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			o ED/or designee will review Emergency preparedness program with QAPI team annually to ensure compliance. o By what date the systemic changes will be completed o 10/11/2018 o Facility requests desk review in lieu of revisit	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/11/18 Facility Number: 000338 Provider Number: 155441 AIM Number: 100287590 At this Life Safety Code survey, Corydon Nursing and Rehabilitation 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 II (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors	K 0000		

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CORYDON NURSING AND REHABILITATION CENTER	315 COUNTRY CLUB RD CORYDON, IN 47112

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	and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 38 and had a census of 27 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except two detached sheds used for facility storage. Quality Review completed on 09/17/18 - DA			
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to			

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	release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation, record review, and interview, the facility failed to ensure the facility failed to ensure 3 of 3 exits	K 0222	K 222 Egress Doors o What corrective action (s) will	10/11/2018

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	had a code posted for locking devices that did not require special knowledge to open. LSC 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. LSC 7.2.1.5.3 Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. This deficient practice could affect all occupants. Findings include: Based on observation with the Maintenance Director on 09/11/18 between 10:40 a.m. and 11:52 a.m., all exit doors were held in the locked position with a magnetic hold down device. Furthermore, the exit door was equipped with an electronic keypad entry system that allowed staff to open the locked exit doors with a combination. A sign on each exit indicated the code required was the last four digits of the facility's phone number. Based on an interview at the time of each observation, the Maintenance Director acknowledged the last four digits of the facility's phone number was special knowledge that alert and oriented residents and visitors may not have or know. 3.1-19(b)		be accomplished for those residents found to have been affected by the deficient practice; o All exit doors have been posted with an exit code that does not require a key, tool or special knowledge to operate on 10/1/2018. o How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; o Facility maintenance director has meet with Corporate Facility Director to ensure all fire doors are in compliance with the applicable National Fire Protection Association's (NFPA) Code. Any doors that are non-compliant with standards will be reported to Facility ED/designee and be replaced/repaired immediately. o What measures will be into place or what systemic changes will be made to ensure that the deficient practice does not occur; o Education given to all employees to report directly to Facility ED/designee if any deficiencies of Doors are noticed on 10/2/2018 also facility maintenance director has added door code postings to daily	

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			mechanical check 10/2/2018 for continued compliance assurance. o How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place o Facility Manager/designee will report monthly x 6 month to the Administrator. Also monitoring is reviewed monthly by the QAPI team to ensure compliance. By what date the systemic changes will be completed o 10/11/2018 o Facility requests desk review in lieu of revisit	
K 0223 SS=E Bldg. 01	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility	K 0223	K223 Doors with Self-Closing	10/11/2018

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	failed to ensure 1 of 1 Maintenance office corridor door was only held open by a release device complying with LSC 7.2.1.8.2 that automatically closes such doors upon activation of the fire alarm system. This deficient practice could affect staff and at least 10 residents. Findings include: Based on observation with the Maintenance Director on 09/11/18 at 11:29 a.m., the Maintenance Office corridor door was held open by a device on the wall. The Maintenance Office was open to the Laundry Room. The Laundry room contained fuel-fired dryers. Based on interview at the time of observation, the Maintenance Director confirmed the hold open device does not release with the fire alarm. 3.1-19(b)		Devices o What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; o On 9/11/2018, The Maintenance Director removed the device from door and provided education to staff. On 9/19/2018 Maintenance Director provided in-service to staff on the importance of not propping open self-closing doors. o 9/11/2018 Sign was placed on back of door advising “Do not prop doors”. o How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; o Residents currently living in the facility, visitors and staff have the potential to be affected by this alleged deficient practice. o On 9/19/2018 Maintenance Director provided in-service to staff on the importance of not propping open self-closing doors. o 9/11/2018 Sign was placed on back of door advising “Do not prop doors o What measures will be into place or what systemic changes will be made to ensure that the	

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			deficient practice does not occur; o Maintenance Director will ensure doors to rooms equipped are closed and not propped open. In addition, inspected weekly then verified by the Executive Director. Any concerns will be addressed immediately. o How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place o Maintenance Director will review with ED monthly during QAPI Meeting. If 100% threshold is not achieved, an action plan will be developed. By what date the systemic changes will be completed o 10/11/2018 o Facility requests desk review in lieu of revisit	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation,			

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	should be included on Form CMS-2567. Based on record review and interview, the facility failed to ensure documentation for the preventative maintenance of battery operated smoke alarms in resident rooms in 2 of 2 smoke compartments was complete. NFPA 72 14.2.1.1.1 states to ensure operations integrity, the system shall have an inspection, testing, and maintenance program. NFPA 72 29.10 states fire-warning equipment shall be maintained and tested in accordance with manufacturer's published instructions and per the requirements of Chapter 14. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 09/11/18 between 9:04 a.m. and 9:49 a.m., the battery operated smoke alarm maintenance documentation failed to indicate smoke alarm battery replacement was performed since July 2017. No documentation was available regarding the smoke alarm manufacturer's recommendations. Based on interview at the time of record review, the Maintenance Director confirmed smoke alarm battery replacement has not been documented for at least a year. 3.1-19(b)	K 0300	K 300 Protection – Other o What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; o All smoke detectors were identified and all batteries were replaced in the smoke detectors on 10/2/2018. o How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; o On 10/2/2018 all batteries will be replaced in the smoke detectors. o What measures will be into place or what systemic changes will be made to ensure that the deficient practice does not occur; o The measures put into place and a systemic change made to ensure the deficient practice not reoccur: On 10/2/2018 monitoring & recording when smoke detector batteries are changed was added to the TELS . o Maintenance Director was educated by ED regarding annual change of batteries (or as per manufacturer suggestion on 10/2/2018.	10/11/2018

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			o How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place o To ensure the deficient practice does not reoccur, the monitoring system established is to: Administrator / Designee will monitor for compliance. Any issues will be addressed immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine what continued auditing is necessary once 100% compliance threshold is achieved. This plan to be amended when indicated. o By what date the systemic changes will be completed o 10/11/2018 o Facility requests desk review in lieu of revisit	
K 0324 SS=D 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, 19.3.2.5.2 * cooking facilities open to the corridor in			

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	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 only. Findings include: Based on observation with the Maintenance Director on 09/11/18 at 11:05 p.m., the Kitchen contained a UL 300 hood system. Based on interview, the Dining Manager was asked what she would do if there was a large grease fire underneath the hood. She replied she would grab the K class fire extinguisher. She failed to indicate pulling the hood pull station. 3.1-19(b)	K 0324	K324 Cooking Facilities o What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; o Instructions for manually operating the fire extinguishing system have been posted conspicuously in the kitchen on 9/19/2018. o How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; o As noted in the 2567, this deficient practice could affect kitchen staff. o All Staff have been instructed in the use of the UL 300 hood system on 9/19/2018 Instructions on its use have been added to the specific job orientation of kitchen staff 10/2/2018	10/11/2018

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			o What measures will be into place or what systemic changes will be made to ensure that the deficient practice does not occur; o All Staff have been instructed in the use of the UL 300 hood system on 9/19/2018 Instructions on its use have been added to the specific job orientation of kitchen staff 10/2/2018 o How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place o Verification that the hood use instructions remain posted have been added to the maintenance daily check sheet. Said rounds will be conducted by the Maintenance Supervisor (or designee) and will take place 5 x per week for assured compliance. Results of this audit will be presented to QAPI for further need for monitoring. o By what date the systemic changes will be completed o 10/11/2018 o Facility requests desk review in lieu of revisit	

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K 0331 SS=F Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). Based on observation and interview, the facility failed to ensure materials used as an interior finish on the walls of 6 of 6 corridors had a flame spread rating of Class A or Class B in accordance with 19.3.3.1. LSC 101 10.2.3.4 states products required to be tested in accordance with ASTM E 84, Standard Test Method For Surface Burning Characteristics of Building Materials or ANSI/UL 723, Standard for Test for Surface Burning Characteristics of Building Materials shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75	K 0331	K 331 Interior Wall and Ceiling Finish o What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; o Fire protectant will be applied to the wainscoting wood simulated panels to ensure it has a flame spread classification of Class B by 10/11/2018 o How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; o All residents have the potential to be affected by the alleged deficient practice. o The facility has been inspected to ensure that other interior walls or ceilings have finishes in accordance with 19.3.3.1 LSC 101 10.2.3.4. 10/11/2018 by the ED	10/11/2018

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	but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect all occupants. Findings include: Based on observation with the Maintenance Director on 09/11/18 between 10:40 a.m. and 11:52 a.m., wainscoting was applied to the walls throughout the building in some rooms and corridors. Based on interview at the time of observation, the Maintenance Director provided the MSDS sheet but was unable to provide interior finish documentation for a flame spread classification of Class A or B. 3.1-19(b)		and the Maintenance Director o What measures will be into place or what systemic changes will be made to ensure that the deficient practice does not occur; o Interior walls and ceilings will be examined on a regular basis by the Maintenance Supervisor or his designee to ensure they have finishes in accordance with 19.3.3.1 LSC 101 10.2.3.4. o The Maintenance Supervisor will be educated on the importance of interior walls or ceilings having finishes in accordance with 19.3.3.1 LSC 101 10.2.3.4. by 10/11/2018 by ED. o How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place o A preventative maintenance form will be used to document the examinations of the interior walls and ceilings monthly times three and quarterly thereafter by the Maintenance Supervisor or his designee. Results will be reported monthly to the ED who will make any needed recommendations. The Maintenance Supervisor or his designee will be responsible for follow up.	

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			o By what date the systemic changes will be completed o 10/11/2018 o Facility requests desk review in lieu of revisit	
K 0355 SS=D 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 ensure 1 of 1 Boiler room portable fire extinguishers was installed correctly in accordance with 19.3.5.12. NFPA 10, the Standard for Portable Fire Extinguishers, 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 pounds shall be installed so that the top of the fire extinguisher is not more than 5 feet above the floor. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Director on 09/11/18 at 11:16 a.m., the Boiler room fire extinguisher measured at least 72 inches from the top of the extinguisher to the floor. Based on interview at the time of observation, the Maintenance Director confirmed the fire extinguisher was higher than he was and he confirmed he was six foot two inches. 3.1-19(b)	K 0355	K 355 Portable Fire Extinguishers o What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; o AN audit of the facility was conducted 9/11/2018 to assure that all fire extinguishers meet the applicable standards. The one deficient fire extinguisher was re-located to the appropriate height on 9/11/2018. o How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; o All residents have the potential to be affected by the alleged deficient practice. o The maintenance director has added fire extinguisher condition	10/11/2018

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	155441	A. BUILDING 01 B. WING	09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORYDON NURSING AND REHABILITATION CENTER	315 COUNTRY CLUB RD CORYDON, IN 47112

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			and inspection to his daily mechanical check sheet 10/2/2018 for assured compliance. o What measures will be into place or what systemic changes will be made to ensure that the deficient practice does not occur; o Fire extinguisher conditions and mounting has been added to the daily mechanical check sheet by the Maintenance Supervisor to ensure they meet and maintain compliance o How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place o quality assurance program will be put into place? Any deficiencies will be immediately corrected and reported to the ED, The Maintenance Supervisor or his designee will be responsible for follow up. o By what date the systemic changes will be completed o 10/11/2018 o Facility requests desk review in lieu of revisit	
K 0363 SS=E	NFPA 101 Corridor - Doors			

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Bldg. 01	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. 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			

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	devices, etc. Based on observation and interview, the facility failed to ensure 1 of 1 Central Supply room and 1 of 1 Activity Director's office corridor doors had no impediment to closing and positively latched into the frame. This deficient practice could affect staff and at least 10 residents. Findings include: Based on observation with the Maintenance Director on 09/11/18 at 11:28 a.m. then again at 11:36 a.m., the Central Supply room contained a door stop. Then again, the Activity Director's office contained a door stop. Based on interview at the time of each observation, the Maintenance Director confirmed each door was prevented from closing with a door stop. 3.1-19(b)	K 0363	K363 Corridor – Doors o What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; o All door stops used to prop open any door have been removed on 9/11/2018. o The Maintenance Director and the Administrator have completed walking rounds in the facility to verify that no additional door stops are being used in the facility 9/19/2018. o All staff has been in serviced that door stops are not permissible and will not be allowed in the facility on 9/19/2018. o How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; o All residents have the potential to be affected by the alleged deficient practice o The Maintenance Director/ Designee will add “Door stops” to the daily mechanical check sheet, which will identify if any door stops are being utilized in any locations throughout the facility. o What measures will be into place or what systemic changes will be made to ensure that the	10/11/2018

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			deficient practice does not occur; o The Maintenance Director/ Designee will add “Door stops” to the daily mechanical check sheet, which will identify if any door stops are being utilized in any locations throughout the facility. o Specifically, any and all door stops will be removed by the Maintenance director or designee. o Staff persons who utilize door stops in the facility will be summarily disciplined as the use of door stops are identified. o How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place o The results of the daily mechanical check sheet will be reviewed at the monthly Quality Assurance Meeting for a period of six months to allow for tracking and trending, recommendations by the committee and follow-up. If no further trends are identified by the committee after the six-month period of review, the committee will then review the audit tools on an as needed basis. The Executive Director/ Designee will ensure that the recommendations of the committee are completed to allow for regulatory compliance.	

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