STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155673	A. BUILDING -- B. WING	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MARKLE HEALTH & REHABILITATION	170 N TRACY ST MARKLE, IN 46770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/10/23 Facility Number: 000544 Provider Number: 155673 AIM Number: 100267340 At this Emergency Preparedness survey, Markle Health and Rehabilitation was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 86 and had a census of 70 at the time of this survey. Quality Review completed on 08/15/23	E 0000	Markle Health and Rehabilitation is alleging compliance on 9.10.23 and is requesting paper compliance for the annual life safety code recertification and state licensure survey.	
E 0026 SS=C Bldg. --	403.748(b)(8), 416.54(b)(6), 418.113(b)(6)(C)(iv), 441.184(b)(8), 482.15(b)(8), 483.475(b)(8), 483.73(b)(8), 485.625(b)(8), 485.920(b)(7), 494.62(b)(7) Roles Under a Waiver Declared by Secretary §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Moore	Administrator	08/31/2023

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	section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [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. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. Based on record review and interview, the facility failed to ensure the Emergency Preparedness Plan (EEP) 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 records review with the Maintenance Director and Administrator on 08/10/23 at 9:38 a.m., a complete 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. There was a sentence that stated, "If a 1135 waiver is declared, the facility will cooperate with emergency	E 0026	E 306 Roles under a waiver declared by the Secretary - 1135 Waiver What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · 1135 Waiver policy will be updated to include information on policy and procedure and will be implemented into the facility's emergency preparedness program. How other residents having the potential to be affected by the same deficient practice will be	09/10/2023

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	management personnel," but information on the policies or procedures were not stated. Based on interview at the time of record review the Maintenance Director acknowledged the1135 waiver policy was incomplete. The finding was reviewed with the Maintenance Director, Administrator, and the DON at the exit conference.		identified and what corrective action(s) will be taken; · All residents have the potential to be affected by the deficient practice. · 1135 Waiver policy will be updated to include information on policy and procedure and will be implemented into the facility's emergency preparedness program. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · Updated 1135 Waiver policy will be reviewed with IDT by ED at next monthly QAPI meeting · All-staff will be in-serviced on updated 1135 Waiver policy by 9/10/23 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director.	

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			· CQI tool identified 1135 Waiver will be completed weekly x 4 weeks, monthly times 3 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 9/10/23 Paper compliance is requested.	
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: 08/10/23 Facility Number: 000544 Provider Number: 155673 AIM Number: 100267340 At this Life Safety Code survey, Markle Health and Rehabilitation 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.	K 0000	Markle Health and Rehabilitation is alleging compliance on 9.10.23 and is requesting paper compliance for the annual life safety code recertification and state licensure survey.	

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	This one-story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery-operated smoke detectors in the resident rooms. The facility has a capacity of 86 and had a census of 70 at the time of this survey. All areas where residents have customary access were sprinklered. The facility had a detached barn providing facility services including storage of beds and other maintenance equipment that was not sprinklered. Quality Review completed on 08/15/23			
K 0271 SS=E 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 1 of 2 exit discharges with handrails was readily accessible and safe to use at all times. LSC Section 7.2.5.4.1 states guards complying with LSC 7.2.2.4 shall be provided for ramps, LSC 7.2.5.4.2 states handrails complying with LSC 7.2.2.4 shall be provided along both sides of a ramp run with a rise greater than 6 in. (150 mm). This deficient practice could affect staff exiting from the service hall. Findings include:	K 0271	K271 Discharge from Exits What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · 4ft fence system handrails along service hall egress sidewalk were repaired. Broken supports repaired and fencing was secured and is no longer loose or moving	09/10/2023

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	Based on an observation with the Maintenance Director and the Administrator on 08/10/23 at 1:30 p.m., along the service hall exit sidewalk the 4-foot-high fence system with handrails which protected persons from falling down the slope was loose, broken from supports, and could be pushed back and forth in two spots. This condition made the fence system unsteady for someone using the handrails for support or protection. Based on an interview at the time of observation, the Maintenance Director stated the fence system was loose, broken and needed repaired. The finding was reviewed with the Maintenance Director, Administrator, and the DON at the exit conference. 3.1-19(b)		back and forth. 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; · Maintenance director inspected all areas of egress sidewalk handrails and found no additional areas of concern What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · Maintenance director will inspect all areas of egress sidewalk handrails monthly and will report findings during monthly QAPI meetings How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive	

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			Director. - CQI tool identified as Egress Sidewalk Handrails will be completed weekly x 4 weeks, monthly times 3 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 9/10/23 Paper compliance is requested.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.			

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	19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of 1 COVID storage rooms with large amounts of combustible storage and greater than 50 square feet was protected as a hazardous area. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation with Maintenance Director and Administrator on 08/10/23 at 11:38 a.m., the COVID storage room contained over 20 boxes of supplies and was greater than 50 square feet making this a hazardous area. The storage room was not protected as a hazardous area because the corridor door to the room was not self-closing or automatic closing. Based on interview at the time of observation, the Maintenance Director agreed the storage room contained large amount of combustible storage, was larger than 50 square feet, and the corridor door to the room was not self-closing. The finding was reviewed with the Maintenance Director, Administrator, and the DON at the exit	K 0321	K321 Hazardous Areas Enclosure What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - Self-closure device installed on Covid storage room door 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 this deficient practice - Maintenance director inspected all storage areas/hazardous areas to ensure self-closure devices were in	09/10/2023

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	conference. 3.1-19(b)		place. No other areas of concern were noted. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · Maintenance director will inspect all storage areas/hazardous areas monthly to ensure self-closure devices are in place and will install as needed and will report findings during monthly QAPI meetings How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. - CQI tool identified Hazardous Areas Enclosure will be completed weekly x 4 weeks, monthly times 3 months, and quarterly thereafter until compliance is achieved. - If Threshold of 100% is not met, an action plan will be developed to ensure compliance.	

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			By what date the systemic changes will be completed; · Completion date: 9/10/23 Paper compliance is requested.	
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, 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 1 of 1 kitchens eliminated any unacceptable degree of risk by ensuring staff could activate the suppression system manual actuation device without being endangered. NFPA 96 2011 edition, section 1.4.2 states in those cases where the authority having jurisdiction determines that the existing situation presents an	K 0324	**K 324 Cooking Facilities** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · The suppression system manual actuation device will be	09/10/2023

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	unacceptable degree of risk, the authority having jurisdiction shall be permitted to apply retroactively any portions of this standard deemed appropriate. Section 10.5.1.1 states at least one manual actuation device shall be located a minimum of 10 feet and a maximum of 20 feet from the protected kitchen appliance(s) within the path of egress. This deficient practice could affect staff in the kitchen and 45 residents in the dining room. Findings include: Based on observation with the Maintenance Director and Administrator on 08/10/23 a 1:13 p.m., the kitchen was provided with a UL 300 hood system and a K-class fire extinguisher with posted instructions. The suppression system manual actuation device was located within a foot of cooking equipment and a suppression spry nozzle. This condition created a degree of risk to statt because staff could be exposed to fire if trying to activate the suppression system manual actuation device. Based on interview at the time of observation, the Maintenance Director agreed the suppression system manual actuation device was next to cooking equipment. The finding was reviewed with the Maintenance Director, Administrator, and the DON at the exit conference. 3.1-19(b)		relocated to a distance of at least 10feet and no more than 20feet from cooking equipment and a suppression spray nozzle. 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 in dining room have the potential to be affected by the deficient practice. · Suppression system will be inspected by vendor for compliance with regulations and immediately correct any areas of concern if noted 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 inspect system monthly, correct areas of concern, if noted, immediately and will report findings during monthly QAPI meetings. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be	

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			monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as Cooking Facilities will be completed weekly x 4 weeks, monthly times 3 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 9/10/23	
K 0351 SS=F Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13,			

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	Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility did not provide adequate signage for 1 of 1 fire department connection (FDC). NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, 13.7 Fire Department Connections. 13.7.1 Fire department connections shall be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. This deficient practice could affect all residents. Findings include: Based on observation with the Maintenance Director and Administrator on 08/10/23 at 9:38 a.m., the FDC located by the front parking lot was faded and unreadable. Based on interview at the time of observation, the Maintenance Director stated the FDC sign needed to be replaced. The finding was reviewed with the Maintenance Director, Administrator, and the DON at the exit conference. 3.1-19(b)	K 0351	**K 351 Sprinkler System Installation** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · The Fire Department Connection (FDC) sign has been replaced with a new, non-faded and easily readable sign 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 deficient practice. · The Fire Department Connection (FDC) sign has been replaced with a new, non-faded and easily readable sign. No other concerns noted. 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 inspect FDC signage monthly and will report findings during monthly QAPI. If noted to be faded or unreadable,	09/10/2023

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MARKLE HEALTH & REHABILITATION	170 N TRACY ST MARKLE, IN 46770

(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
			sign will be replaced immediately. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as FDC Sign will be completed weekly x 4 weeks, monthly times 3 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 9/10/23	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155673	A. BUILDING 01 B. WING	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MARKLE HEALTH & REHABILITATION	170 N TRACY ST MARKLE, IN 46770

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	Describe any mechanical smoke control system in REMARKS. #1.) Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 3 of 5 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 40 residents in four smoke compartments. Findings include: Based on observations with the Maintenance Director and Administrator on 08/10/23 between 1:45 p.m. and 2:15 p.m., the following unsealed penetrations were discovered: a) Above the drop ceiling of the service hall smoke wall had a 3/4-inch unsealed gap around pipes. b) Above the drop ceiling of the 200-hall smoke wall had a 3/4-inch unsealed gap around wires and a one-inch hole through the wall. c) Above the drop ceiling of the 100- hall smoke wall had a 3/4-inch unsealed gap around wires. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned smoke walls contained unsealed penetrations. #2.) Based on observations, records review, and	K 0372	**K 372 Subdivision of Building Spaces – Smoke Barriers** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; #1 - Three smoke barrier walls above drop ceiling in service hall, 100 hall and 200 hall were repaired using fire caulk to meet requirements for smoke penetrations. #2 - Smoke barrier wall above drop ceiling in service hall was repaired by removing joint compound and sealing with fire caulk to meet requirements for smoke penetrations 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 deficient practices. · All smoke barrier walls, ceiling areas and attic were inspected for (#1) penetrations and/or (#2) use of joint compound, no additional areas were identified. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;	09/10/2023

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	interview, the facility failed to ensure 1 of 5 smoke barrier walls were constructed to requirements according to the authority having jurisdiction (AHJ). LSC 8.2.3.1 states the fire resistance of structural elements and building assemblies shall be determined in accordance with test procedure set forth in ASTM E 119, Standard Test Methods for Fire Tests of Building Construction and Materials, or ANSI/UL 263, Standard for Fire Tests of Building Construction and Materials; other approved test methods; or analytical methods approved by the AHJ. The AHJ requires penetrations in smoke barriers to be sealed with a firestop system or device tested in accordance with ASTM E 814. This deficient practice could affect 30 residents in two smoke compartments. Findings include: Based on observations with the Maintenance Director and Administrator on 08/10/23 at 1:45 p.m., above the drop ceiling of the service hall smoke wall five penetrations were sealed with joint compound. Based on interview at the time of observation, the Maintenance Director and agree smoke wall penetration were sealed with joint compound. The findings were reviewed with the Maintenance Director, Administrator, and the DON at the exit conference. 3.1-19(b)		· The Maintenance Director or designee will conduct an audit to identify (#1) penetrations and/or (#2) use of joint compound in the fire walls, ceilings and attic weekly for 4 weeks, then monthly for 3 months and quarterly thereafter until compliance is achieved. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified Smoke Barrier will be completed weekly x 4 weeks, monthly times 3 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 9/10/23 Paper compliance is requested.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING			

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	Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 5 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. NFPA 101 2012 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect 30 residents in two smoke compartments. Finding include: Based on observations with the Maintenance Director and Administrator on 08/10/23 at 12:50 p.m. the smoke barrier doors entering the 100-hall had a 1/4-inch gap between the doors when closed. Based on an interview at the time of observation, the Maintenance Director agreed there was a gap larger than 1/8 inch between the smoke doors when closed. The finding was reviewed with the Maintenance Director, Administrator, and the DON at the exit conference. 3.1-19(b)	K 0374	**K 374 Subdivision of Building Spaces – Smoke Barrier Doors** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · · 100 hall smoke barrier door has been adjusted to eliminate 1/4 inch gap 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 deficient practice. · All smoke barrier doors were inspected for gaps by Maintenance Director. No additional concerns were identified. What measures will be put into place or what systemic changes will be made to ensure that the	09/10/2023

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			deficient practice does not recur; · · The Maintenance Director or designee will inspect all smoke barrier doors weekly and will immediately make adjustments/repairs as needed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · · CQI tool identified Smoke Barrier Doors will be completed weekly x 4 weeks, monthly times 3 months, and quarterly thereafter until compliance is achieved. · · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 9/10/23	
K 0761 SS=F Bldg. 01	Based on records review and interview the facility failed to ensure annual inspection and testing of 6 of 6 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by	K 0761	**K 761 Maintenance, Inspection and Testing - Doors** What corrective action(s) will be accomplished for those residents	09/10/2023

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	19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or		found to have been affected by the deficient practice; · · All six fire door assemblies were re-inspected using an itemized checklist to document verification of the 11 required items for each door. 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 deficient practice. · All six fire door assemblies were re-inspected using an itemized checklist to document verification of the 11 required items for each door. 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 inspect all fire door assemblies annually using an itemized checklist to document verification of all 11 required items for each door. · · Itemized checklists will be signed by Maintenance Director or designee and retained for inspection How the corrective action(s) will be	

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	prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include: Based on record review with the Maintenance Director and Administrator on 08/10/23 at 10:19 a.m., the documentation of an annual inspection for the six fire door assemblies were not itemized. In the TELS computer system the fire door inspection was marked as complete, but it did not indicate if the 11 required items were verified for each door. Based on interview at the time of records review and observation, the Maintenance Director stated he used a checklist with the required items, but the checked items were not documented. The finding was reviewed with the Maintenance Director, Administrator, and the DON at the exit conference. 3.1-19(b)		monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · · CQI tool identified as Fire Door Inspections will be completed weekly x 4 weeks, monthly times 3 months, and quarterly thereafter until compliance is achieved. · · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 9/10/23	