STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155720	A. BUILDING -- B. WING	10/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CATHEDRAL HEALTH CARE CENTER	520 W 9TH ST JASPER, IN 47546

(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: 10/02/23 Facility Number: 000315 Provider Number: 155720 AIM Number: 100289030 At this Emergency Preparedness survey, Cathedral Health Care Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 65 certified beds and had a census of 52 at the time of this visit. Quality Review completed on 10/11/23 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective November 1st, 2023 to the survey completed on October 2nd, 2023. We respectfully request a paper review and will provide any additional information requested.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Allision Betz	HFA	10/26/2023

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

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	§494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (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 all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [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. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.			

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	. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all residents in the facility. Findings include: Based on review of the Fire and Disaster Plan on 10/02/23 between 8:45 a.m. and 12:30 p.m. with the Maintenance Director present, the facility did provide an emergency preparedness manual, however, it has not been reviewed and updated during the past twelve months. There was no date of most recent review and update found. Furthermore, there was a table of contents located at the front of the book, however, the book did not follow the order of the table of contents. Based on interview at the time of review, the Maintenance Director confirmed there was no date provided in the Fire and Disaster Plan to show it has been reviewed and updated within the past twelve months. Furthermore, the Maintenance Director agreed the order of the book did not match the table of contents. This finding was reviewed with the Maintenance Director during the exit conference.	E 0004	***The correction action taken for those residents found to be affected by the deficient practice include:*** No residents were found to be affected by the deficient practice. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be affected but none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The Administrator/Maintenance Director is responsible for ensuring that the disaster preparedness plan is reviewed annually, and the table of contents matches the order of the book. The disaster plan has been updated and reviewed. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The Administrator, or designee, will be responsible for ensuring that the disaster preparedness plan is appropriately reviewed and updated, and the table of contents	11/01/2023

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			matches the order of the book. The Quality Assurance Committee will review the disaster preparedness policy a minimum of annually or more often if changes for compliance with recommendations as needed. ***The date the systemic changes will be completed.*** November 1st, 2023	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [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 section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must			

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	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 section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization 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 section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility 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 section. The policies and procedures must be reviewed and updated at least every 2			

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	years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: Based on review of the Fire and Disaster Plan on 10/02/23 between 8:45 a.m. and 12:30 p.m. with the Maintenance Director present, there was documentation in the plan for facility policies and procedures, however the policies and procedures have not been reviewed by the facility within the most recent twelve month period. There was no date of most recent review and update found. Based on interview at the time of review, the Maintenance Director said he thought the policies and procedures portion of the Fire and Disaster Plan had been reviewed and updated within the past twelve months, however, agreed there was no review and update information found. This finding was reviewed with the Maintenance Director during the exit conference.	E 0013	***The correction action taken for those residents found to be affected by the deficient practice include:*** No residents were found to be affected by the deficient practice. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be affected but none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The Administrator/Maintenance Director is responsible for ensuring that the fire and disaster plan policies and procedures are reviewed annually. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The Administrator, or designee, will be responsible for ensuring that the fire and disaster plan	11/01/2023

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			policies and procedures are reviewed annually. The Quality Assurance Committee will review the disaster preparedness policy a minimum of annually or more often if changes for compliance with recommendations as needed. ***The date the systemic changes will be completed.*** November 1st, 2023	
E 0015 SS=C Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1) Subsistence Needs for Staff and Patients §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [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 section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical			

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	supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to	E 0015	***The correction action taken for those residents found to be affected by the deficient practice include:*** No residents were found to be affected by the deficient practice. ***Other residents that have the***	11/01/2023

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	maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: Based on review of the Fire and Disaster Plan on 10/02/23 between 8:45 a.m. and 12:30 p.m. with the Maintenance Director present, the plan provided did not address medical, pharmaceutical supplies, and the loss of sewage and waste disposal to protect residents health and safety in an emergency. Based on interview at the time of records review, the Maintenance Director confirmed the plan provided did not address medical, pharmaceutical supplies, and the loss of sewage and waste disposal to protect residents health and safety in an emergency. This finding was reviewed with the Maintenance Director during the exit conference.		***potential to be affected have been identified by:*** Potentially all residents could be affected but none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The Administrator/Maintenance Director is responsible for ensuring that the disaster plan meets the requirements. Documents added to disaster plan. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The Administrator, or designee, will be responsible for ensuring that the disaster preparedness plan is appropriately reviewed and updated. The Quality Assurance Committee will review the disaster preparedness policy a minimum of annually or more often if changes for compliance with recommendations as needed. ***The date the systemic changes will be completed.*** November 1st, 2023	

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E 0020 SS=C Bldg. --	403.748(b)(3), 416.54(b)(2), 418.113(b)(6)(ii), 441.184(b)(3), 482.15(b)(3), 483.475(b)(3), 483.73(b)(3), 485.625(b)(3), 485.68(b)(1), 485.727(b)(1), 485.920(b)(2), 491.12(b)(1), 494.62(b)(2) Policies for Evac. and Primary/Alt. Comm. §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2) [(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 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:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCIs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation.			

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	(iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include information for safe evacuation from the LTC facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance in accordance with 42 CFR 483.73(b) (3). This deficient practice could affect all occupants. Findings include: Based on review of the Fire and Disaster Plan on 10/02/23 between 8:45 a.m. and 12:30 p.m. with the Maintenance Director present, there was an evacuation plan within the Fire and Disaster Plan,	E 0020	***The correction action taken for those residents found to be affected by the deficient practice include:*** No residents were found to be affected by the deficient practice. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be affected but none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur***	11/01/2023

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	however, the following was noted: a. One of the facility's listed as an evacuation site was the 10th Street School in Jasper, which is no longer in existence. b. The procedures of evacuation do not discuss the evacuation of a multi-story building. This facility is a two story facility with a basement. Based on interview at the time of record review, the Maintenance Director acknowledged the discrepancies in the evacuation procedures within the Fire and Disaster Plan. This finding was reviewed with the Maintenance Director during the exit conference.		***include:*** The Administrator/Maintenance Director is responsible for ensuring that the disaster preparedness plan is accurate. Disaster to ensure no longer states 10th street school as evacuation site and multi-story building evacuation added into plan. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The Administrator, or designee, will be responsible for ensuring that the disaster preparedness plan is appropriately reviewed and updated. The Quality Assurance Committee will review the disaster preparedness a minimum of annually or more often if changes for compliance with recommendations as needed. ***The date the systemic changes will be completed.*** November 1st, 2023	
E 0025 SS=C Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b)(7), 482.15(b)(7), 483.475(b)(7), 483.73(b)(7), 485.625(b)(7), 485.920(b)(6), 494.62(b)(6) Arrangement with Other Facilities §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7),			

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	§485.920(b)(6), §494.62(b)(6). [(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 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:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to			

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	155720	A. BUILDING -- B. WING	10/02/2023

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	maintain the continuity of non-medical services to RNHCI patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents in accordance with 42 CFR 483.73(b)(7). This deficient practice could affect all occupants. Findings include: Based on review of the Fire and Safety Plan on 10/02/23 between 8:45 a.m. and 12:30 p.m. with the Maintenance Director present, documentation of emergency preparedness policies and procedures including the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations was available for review, however, one of the facility's on the list was the 10th Street School which is no longer in existence. Based on interview at the time of record review, the Maintenance Director agreed the documentation of arrangements with other facilities needs to be corrected and updated. This finding was reviewed with the Maintenance Director during the exit conference.	E 0025	***The correction action taken for those residents found to be affected by the deficient practice include:*** No residents were found to be affected by the deficient practice. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be affected but none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The Administrator/Maintenance Director is responsible for ensuring that the disaster preparedness plan is accurate. Disaster plan updated with correct facilities. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The Administrator, or designee, will be responsible for ensuring that the disaster preparedness plan is appropriately reviewed and updated. The Quality Assurance Committee will review the disaster preparedness at a minimum of	11/01/2023

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			annually or more often if changes for compliance with recommendations as needed. ***The date the systemic changes will be completed.*** November 1st, 2023	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the Fire and Disaster Plan on	E 0029	***The correction action taken for those residents found to be affected by the deficient practice include:*** No residents were found to be affected by the deficient practice. ***Other residents that have the potential to be affected have been identified by:***	11/01/2023

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	10/02/23 between 8:45 a.m. and 12:30 p.m. with the Maintenance Director present, the facility's plan provided did include a plan to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws, however the communication plan has not been reviewed by the facility within the most recent twelve month period. There was no date of most recent review and update found. Based on interview at the time of review, the Maintenance Director said the Fire and Disaster Plan's communication plan has not been reviewed and updated within the past twelve months. This finding was reviewed with the Maintenance Director during the exit conference.		Potentially all residents could be affected but none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The Administrator/Maintenance Director is responsible for ensuring that the disaster preparedness communication plan disaster is reviewed annually. The plan has been updated and reviewed. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The Administrator, or designee, will be responsible for ensuring that the disaster preparedness communication plan is appropriately reviewed and updated. The Quality Assurance Committee will review the disaster preparedness communication plan a minimum of annually or more often if changes for compliance with recommendations as needed. ***The date the systemic changes will be completed.*** November 1st, 2023	

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E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the			

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	communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.			
	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants.	E 0036	***The correction action taken for those residents found to be affected by the deficient practice include:*** No residents were found to be affected by the deficient practice.	11/01/2023

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	Findings include: Based on review of the Fire and Disaster Plan on 10/02/23 between 8:45 a.m. and 12:30 p.m. with the Maintenance Director present, there was documentation available to show the facility had an emergency preparedness training and testing program, however the training and testing program has not been reviewed by the facility within the most recent twelve month period. There was no date of most recent review and update found. Based on interview at the time of review, the Maintenance Director said the Fire and Disaster Plan's training and testing program has not been reviewed and updated within the past twelve months. This finding was reviewed with the Maintenance Director during the exit conference.		***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be affected but none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The Administrator/Maintenance Director is responsible for ensuring that the disaster preparedness plan training and testing is reviewed annually. The disaster plan training and testing has been updated and reviewed. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The Administrator, or designee, will be responsible for ensuring that the disaster preparedness plan training and testing is appropriately reviewed and updated annually. The Quality Assurance Committee will review the disaster preparedness training and testing a minimum of annually or more often if changes for compliance with recommendations as needed. ***The date the systemic changes***	

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			will be completed.	
			November 1st, 2023	
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).	K 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective November 1st, 2023 to the survey completed on October 2nd, 2023. We respectfully request a paper review and will provide any additional information requested.	
	Survey Date: 10/02/23			
	Facility Number: 000315 Provider Number: 155720 AIM Number: 100289030			
	At this Life Safety Code survey, Cathedral Health Care 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 two story facility with a basement was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 65 and had a census of 52 at the time of this survey.			
	All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except a generator			

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	building, and a greenhouse. Quality Review completed on 10/11/23			
K 0211 SS=B Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 5 exit means of egress corridors were continuously maintained free of obstructions. This deficient practice could affect 20 or more residents, as well as staff and visitors. Findings include: Based on observations on 10/02/23 between 12:30 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, there was a chair setting in the main level west corridor next to the water fountain. The chair was not in use at the time of observation and was not connected/tied to the wall or floor. Based on interview at the time of observation, the Maintenance Director acknowledged the chair being stored in the corridor and not connected/tied to the wall or floor and not in use at the time of observation. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)	K 0211	***The correction action taken for those residents found to be affected by the deficient practice include:*** No residents were found to be affected by the deficient practice. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be affected but none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The Administrator/Maintenance Director is responsible for ensuring that the means of egress are in place. A chair setting in main level west corridor by telephone not	11/01/2023

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			being utilized. The chair was removed. Signs posted. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** An audit will be completed by maintenance or designee on all means of egress weekly. Any negative findings will be immediately remedied, and administrator notified. The results of these audits will be reviewed by the Quality Assurance Committee monthly in the Quality Assurance Meeting. ***The date the systemic changes will be completed.*** November 1st, 2023	
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			

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

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	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 1. Based on observation and interview, the facility failed to ensure the means of egress through 13 of 13 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect all residents staff and visitors needing to exit the facility. Findings include: Based on observations on 10/02/23 between 12:30 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, all ten exit doors (stairway and outside exit doors) were posted with the incorrect code to actuate the door release. The Maintenance Director was able to open the door with the correct code. Furthermore, the west stairway access door on the main level was equipped with a magnetic lock with a keypad and the code was not posted. Based on interview at the time of each observation, the Maintenance Director said he changes the code at the beginning of each month but the first day of October was over the weekend and he was preparing to change the codes today, furthermore,	K 0222	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were found to be affected by the deficient practice. ***How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:*** Potentially all residents could be affected but none were identified. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:*** All egress doors were checked. Doors updated with correct code to actuate the door release posted. Doors code to be changed monthly. ***How the corrective action(s) will be monitored to ensure the***	11/01/2023

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	the Maintenance Director said he was not sure why the code was not posted at the main level west stairway access door. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 13 exit door access-controlled keypads was not located between the required 40 to 48 inches vertically above the floor. NFPA 101 at 19.2.2.2.4(3) refers to 7.2.1.6.2. Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 7.2.1.6.2(3)(a) states the manual release device shall be located on the egress side, 40 in. to 48 in. vertically above the floor. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observation on 10/02/23 between 12:30 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, the access-controlled keypad on the main level inside the west stairwell at the outside exit door was located on the wall at six feet vertically above the floor to the bottom of the keypad. This was 12 inches over the required maximum height. Based on interview at the time of observation, the Maintenance Director agreed the keypad was placed to high on the wall. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		***deficient practice will not recur, i.e., what quality assurance program will be put into place:*** An audit will be completed by maintenance or designee on all egress doors monthly. Any negative findings will be immediately remedied, and administrator notified. The results of these audits will be reviewed by the Quality Assurance Committee monthly in the Quality Assurance Meeting. ***The date the systemic changes will be completed:*** November 1st, 2023	

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	3. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 13 locked exit doors was readily and easily accessible for residents, staff, and visitors. This deficient practice could affect all residents, as well as staff and visitors when the basement Auditorium is used. Findings include: Based on observations on 10/02/23 between 12:30 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, the south exit door to the outside stairway from the Auditorium required heavy force to open when the door code was pushed on the keypad. The magnetic locks did release when the code was entered, however, the door took heavy force several times to open. Based on interview at the time of observation, the Maintenance Director acknowledged the exit door required heavy force to open. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)			
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 1 of 10 battery powered emergency light sets was maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided	K 0291	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were found to be affected by the deficient practice.	11/01/2023

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	with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on observations on 10/02/23 between 12:30 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, one of two battery backup light sets located within the generator enclosure did not illuminate when tested several times. Based on interview at the time of observation, the Maintenance Director agreed one of two battery backup light sets within the generator enclosure did not illuminate when tested several times. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		***How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:*** Potentially all residents could be affected but none were identified. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:*** All emergency lightning checked. The only deficient battery backup light set was within generator enclosure. Battery backup light set corrected. ***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:*** An audit will be completed by maintenance or designee on all emergency lighting monthly. Any negative findings will be immediately remedied, and administrator notified. The results of these audits will be reviewed by the Quality Assurance Committee monthly in the Quality Assurance Meeting.	

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			The date the systemic changes will be completed: November 1st, 2023	
K 0321 SS=F 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. 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)			

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	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 egress corridor in the basement area was not used to store combustible material. This deficient practice could affect mostly staff while in the basement, plus residents and visitors while in the adjacent Auditorium. Findings include: Based on observations on 10/02/23 between 12:30 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, the main corridor in the basement area and outside the Auditorium was being used to store many combustible items, such as, cardboard boxes, recliners, other old furniture, pallets, and a variety of other storage items. This area was open to, and a part of the egress corridor. Based on interview at the time of observation, the Maintenance Director said some items have been removed from this area and they are still in the process of cleaning up the rest of the items. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)	K 0321	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents or staff were found to be affected by the deficient practice. ***How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:*** Potentially staff and residents could be affected but none were identified. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:*** Administrator/Maintenance director are responsible for ensuring the main corridor within egress is open. Main corridor area has had items removed. ***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:***	11/01/2023

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			The Maintenance Director/designee will ensure no items are in the main corridor area weekly. The Quality Assurance Committee will review the disaster preparedness policy a minimum of annually or more often if changes for compliance with recommendations as needed. ***The date the systemic changes will be completed:*** November 1, 2023	
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			

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	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 proper use of the UL 300 hood fire suppression system in 1 of 1 kitchen. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 10.5.7 states instruction shall be provided to employees regarding the proper use of portable fire extinguishers and the manual activation of fire-extinguishing equipment. Section 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 kitchen staff plus any residents while in the adjacent main dining room. Findings include: Based on observations on 10/02/23 between 12:30 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, the kitchen was provided with a UL 300 hood system. Based on interview with kitchen staff #1 (head cook), when asked what she would do if there was a fire underneath the hood. She said she didn't really know, but would maybe grab a fire extinguisher. She did not say she would pull the range hood fire suppression system pull station, however, when asked, she did know where it was located. This was acknowledged by the Maintenance Director at the time of observation and interview with the kitchen staff #1 (head cook). The Maintenance Director said more training for kitchen staff would be a priority.	K 0324	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were found to be affected by the deficient practice. ***How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:*** Potentially all residents could be affected but none were identified. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:*** Education provided to all dietary personnel. ***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:*** An audit will be completed by maintenance or designee on dietary personnel knowledge of hood system monthly. Any negative findings will be	11/01/2023

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	This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		immediately remedied, and administrator notified. The results of these audits will be reviewed by the Quality Assurance Committee monthly in the Quality Assurance Meeting. ***The date the systemic changes will be completed:*** November 1st, 2023	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 1 of 1 fire department connection	K 0353	***The corrective action taken for those residents found to be***	11/01/2023

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	was in accordance with NFPA 25, 2011 Edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 13.7.1 requires fire department connections to 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 occupants. Findings include: Based on observations on 10/02/23 between 12:30 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, the facility's fire department connection (FDC) was located on the back side of the facility. There was FDC signage provided at the fire department connection, however, there was no FDC signage at the front of the building for the responding fire department to lead them to the FDC for easy identification. Based on interview at the time of observation, this was acknowledged by the Maintenance Director who agreed there should be FDC signage at the front of the facility. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		***affected by the deficient practice include:*** No residents were found to be affected by the deficient practice. ***How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:*** Potentially all residents could be affected but none were identified. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:*** FDC signage was added to help the fire department identify location of connection. ***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:*** An audit will be completed by maintenance or designee on FDC signage for identifying location of connection annually. Any negative findings will be immediately remedied, and administrator notified. The results of these audits will be reviewed by the Quality Assurance Committee	

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			monthly in the Quality Assurance Meeting. ***The date the systemic changes will be completed:*** November 1st, 2023	
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 34 portable fire extinguishers each month during the past 12 month period. 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	K 0355	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were found to be affected by the deficient practice. ***How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:*** Potentially all residents could be affected but none were identified. ***What measures will be put into place and what systemic***	11/01/2023

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	(6) Indicator for nonrechargeable extinguishers 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 at least 5 residents, as well as staff and visitors. Findings include: Based on observations on 10/02/23 between 12:30 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, fire extinguishers in the Employee Break Room, Physical Therapy room, and the outside generator enclosure were not inspected monthly in August and September of 2023. The annual inspection of all fire extinguishers by the facility's vendor was performed in February of 2023. Based on interview at the time of each observation, the Maintenance Director acknowledged the aforementioned portable fire extinguishers had not been inspected monthly during August and September of 2023. This finding was reviewed with the Maintenance Director during the exit conference.		***changes will be made to ensure that the deficient practice does not recur:*** All portable fire extinguishers checked to ensure monthly checks completed. ***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:*** An audit will be completed by maintenance or designee on all portable fire extinguishers monthly. Any negative findings will be immediately remedied, and administrator notified. The results of these audits will be reviewed by the Quality Assurance Committee monthly in the Quality Assurance Meeting. ***The date the systemic changes will be completed:*** November 1st, 2023	

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	3.1-19(b)			
K 0363 SS=B 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 2 of over 50 corridor doors had no impediment to closing. This deficient practice could affect mostly staff. Findings include: Based on observations on 10/02/23 between 12:30 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, the Director of Nursing office door and the Staff Training room door were both held open with door wedges. Based on interview at the time of each observation, the Maintenance Director both doors being held wide open with door wedges. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)	K 0363	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were found to be affected by the deficient practice. ***How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:*** Potentially all residents could be affected but none were identified. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:*** All corridor doors were checked. Only 2 corridor doors had impediments to closing. Wedges removed from doors. ***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:***	11/01/2023

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			An audit will be completed by maintenance or designee on all corridor doors monthly. Any negative findings will be immediately remedied, and administrator notified. The results of these audits will be reviewed by the Quality Assurance Committee monthly in the Quality Assurance Meeting. ***The date the systemic changes will be completed:*** November 1st, 2023	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 4 sets of smoke barrier doors	K 0374	***The corrective action taken for those residents found to be***	11/01/2023

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	would close completely to form a smoke resistant barrier. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 10/02/23 between 12:30 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, the set of smoke barrier doors between the main level west unit and the center Nurses' Station area did not close completely when tested several times. There was a 1/4 inch to 1/2 inch gap between the entire length of the doors when closed fully. This was acknowledged by the Maintenance Director at the time of observation. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		***affected by the deficient practice include:*** No residents were found to be affected by the deficient practice. ***How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:*** Potentially all residents could be affected but none were identified. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:*** All smoke barrier doors were checked. This smoke barrier door was the only deficient door. Door was adjusted and maintained accordingly. The door closes and latches to meet regulations. ***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:*** An audit will be completed by maintenance or designee on all smoke barrier doors monthly. Any negative findings will be immediately remedied, and administrator notified. Updated	

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			annual latch and gap inspection list. The results of these audits will be reviewed by the Quality Assurance Committee monthly in the Quality Assurance Meeting. ***The date the systemic changes will be completed:*** November 1st, 2023	
K 0531 SS=C Bldg. 01	NFPA 101 Elevators Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 Based on record review, observation, and interview; the facility failed to accurately maintain	K 0531	***The corrective action taken for those residents found to be***	11/01/2023

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	testing documentation for 1 of 2 elevators firefighter recall in accordance with 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with fire fighters' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on record review on 10/02/23 between 8:45 a.m. and 12:30 p.m. with the Maintenance Director present, there was documentation available for the monthly firefighter recall test for the elevators for the past twelve months, however, the documentation provided did not list two separate elevators. Based on interview at the time of record review, the Maintenance Director said the documentation provided for the testing of the firefighter recall was for the two elevators, but was only documented once. Based on observations on 10/02/23 between 12:30 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, both elevators were equipped with a firefighter recall key operation at the main floor level. This was confirmed by the Maintenance Director at the time of each observation. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		***affected by the deficient practice include:*** No residents were found to be affected by the deficient practice. ***How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:*** Potentially all residents could be affected but none were identified. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:*** Monthly firefighters recall test for both elevators was on one form. Each elevator will have its own form ongoing. ***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:*** An audit will be completed by maintenance or designee on elevator firefighters recall test monthly. Any negative findings will be immediately remedied, and administrator notified. The results of these audits will be reviewed by the Quality Assurance Committee	

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			monthly in the Quality Assurance Meeting. ***The date the systemic changes will be completed:*** November 1st, 2023	
K 0761 SS=F Bldg. 01	Based on observation, record review, and interview; the facility failed to ensure a complete annual inspection and testing of 8 of 8 stairway fire door assemblies, and the oxygen transfilling room door assembly was completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 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	K 0761	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were found to be affected by the deficient practice. ***How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:*** Potentially all residents could be affected but none were identified. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:*** All smoke barrier doors were checked. Annual check changed	11/01/2023

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	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 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, as well as staff, and visitors. Findings include: Based on record review on 10/02/23 between 8:45 a.m. and 12:30 p.m. with the Maintenance Director present, the facility was able to provide documentation for the annual inspection of all sets of the facility's smoke barrier door		to show itemized list of the items inspected that passed. All fire door assemblies checked. ***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:*** An audit will be completed by maintenance or designee on all smoke barrier doors and fire door assemblies annually. Any negative findings will be immediately remedied, and administrator notified. The results of these audits will be reviewed by the Quality Assurance Committee monthly in the Quality Assurance Meeting. ***The date the systemic changes will be completed:*** November 1st, 2023	

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	assemblies, however, the documentation provided was only a "Pass" for each set of smoke barrier door assemblies and did not have a itemized list of the items inspected that passed. Furthermore, the facility was unable to provide documentation for an annual inspection of 8 stairway fire door assemblies and 1 oxygen transfilling room fire door assembly. Based on interview at the time of record review, the Maintenance Director said the documentation provided was the only inspection and testing documentation available for the annual inspection/testing of the facility's fire door assemblies. Based on observations during a tour of the facility with the Maintenance Director between 12:30 p.m. and 3:15 p.m., there were 8 stairway fire door assemblies and 1 oxygen transfilling room fire door assembly noted in the facility. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)			
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			

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	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 power strips were not used as a substitute for fixed wiring in 3 of 3 observed staff areas. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff only in three staff only areas. Findings include: Based on observations on 10/02/23 between 12:30 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. There was a coffee maker plugged into a power strip in the Director of Nursing office. b. There was a microwave oven, coffee maker, and refrigerator plugged into a power strip in the Physical Therapy room. c. There was a coffee maker plugged into a power strip which was plugged into another power strip in the Activities room. Based on interview at the time of each	K 0920	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were found to be affected by the deficient practice. ***How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:*** Potentially all residents could be affected but none were identified. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:*** Power strip removed in Director of Nursing office. Power strip removed in therapy room. Power strip removed in activity room.	11/01/2023

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	observation, the Maintenance Director acknowledged the use of the power strips in the three staff areas. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		***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:*** An audit will be completed by maintenance or designee on all power strips monthly. Any negative findings will be immediately remedied, and administrator notified. The results of these audits will be reviewed by the Quality Assurance Committee monthly in the Quality Assurance Meeting. ***The date the systemic changes will be completed:*** November 1st, 2023	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable			

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	containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room where oxygen transferring takes place, was provided with a properly designed mechanical ventilation system. This deficient practice could affect at least 20 residents, staff and visitors. Findings include: Based on observations on 10/02/23 between 12:30 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, the oxygen storage/transfilling room was equipped with a wall mounted mechanically vented exhaust fan, however, the exhaust vent fan was located on the corridor wall above the door and expelled the air from the oxygen storage/transfilling room back into the egress corridor. Based on interview at the time of observation, the Maintenance Director agreed the mechanically vented exhaust fan from the oxygen storage/transfilling room should not be vented to the egress corridor. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)	K 0927	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were found to be affected by the deficient practice. ***How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:*** Potentially all residents could be affected but none were identified. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:*** Facility has had work completed by local HVAC company to have oxygen storage/transfilling room vented to outside of facility. ***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:*** The Administrator, or designee, will be responsible for ensuring that the oxygen storage/transfilling	11/01/2023

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			room ventilation is in proper working order. Administrator, or designee will check ventilation weekly. The Quality Assurance Committee will review the disaster preparedness policy with a focus on oxygen storage and ventilation a minimum of annually or more often if changes for compliance with recommendations as needed. ***The date the systemic changes will be completed:*** November 1st, 2023	