STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155266	A. BUILDING -- B. WING	08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN 46805

(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: 08/09/22 Facility Number: 000167 Provider Number: 155266 AIM Number: 100273740 At this Emergency Preparedness survey, Life Care Center of Fort Wayne was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 125 and had a census of 82 at the time of this survey. Quality Review on 08/12/22.	E 0000		
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: 08/09/22 Facility Number: 000167 Provider Number: 155266 AIM Number: 100273740 At this Life Safety Code survey, Life Care Center of Fort Wayne was found not in compliance with Requirements for Participation in	K 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Life Care of Ft. Wayne respectfully request a paper compliance.	

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

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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type III (200) 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 125 and had a census of 82 at the time of this survey All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a maintenance office/workshop/storage building. Quality Review on 08/12/22.			
K 0211 SS=E 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 #1 Based on observation and interview, the facility failed to ensure 6 of 12 corridor exit doors only contained one latching mechanism to release and open the door. LSC 7.2.1.5.10 states a latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily	K 0211	1. The identified corridor exit doors have been replaced with one locking mechanism, payroll office, administrator office, business office, front store room, rehab room, and rehab kitchen. Parts have been ordered for identified	09/09/2022

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	operated under all lighting conditions. 7.2.1.5.10.4 states the releasing mechanism shall open the door leaf with not more than one releasing operation. 7.2.1.5.10.1 states the releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches, above the finished floor. This deficient practice affects 20 residents in two smoke compartments. Findings include: Based on observation with the Environmental Assistant on 08/09/22 between 11:20 a.m. and 11:40 a.m., the corridor exit doors from the payroll office, administrator office, business office, front storeroom, rehab room, and rehab kitchen were equipped with two latching devices, a latching door turn knob and a separate deadbolt lock. Based on interview at the time of observation, the Environmental Assistant agreed the aforementioned exit doors were equipped with two latching devices. #2 Based on observation and interview, the facility failed to ensure 1 of 2 cooler/freezer doors in the kitchen were able to open from the inside if locked. LSC 19.2.2.1 states doors complying with 7.2.1 shall be permitted. 7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied. This deficient practice could staff in the kitchen. Findings include: Based on observation with the Environmental Assistant on 08/09/22 at 12:47 p.m., the walk-in freezer door could be locked with a padlock, by a key lock from the outside, and had a turn release handle on the inside to open the door if lock. When tested, the release on the freezer door did		lock for the walk in freezer. Hobarts will install upon arrival 1.All residents have the potential to be affected by this alleged deficient practice. All remaining corridor exit doors has been inspected by Environmental Director with no further issues noted. 2.The Environmental Director/Designee was educated on means of egress. 3.The Environmental Director/Designee will inspect corridor exit doors to ensure one locking mechanism 3 X week for 4 weeks, 2 X week for 4 weeks, 1 X week for 4 weeks, then monthly X 3 months. Environmental/Designee will report findings to the Quality Assurance Committee for at least 6 months.	

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	not work by releasing the mechanisms that keeps the doors locked. This condition could trap a person inside the freezer if locked from the outside. Based on interview at the time of observation, the Environmental Assistant agreed the freezer release handle was not working and stated the release mechanism would need to be repaired. The findings were reviewed with the Administrator and Environmental Assistant at the exit conference. 3.1-19(b)			
K 0232 SS=F Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation and interview, the facility failed to meet the clear width requirement for 5 of 5 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor.	K 0232	1.The identified furniture in the corridors has been removed. 2. All residents have the potential to be affected by this alleged deficient practice. All remaining corridors have been inspected by Environmental Director, furniture in these corridors has been removed. 3. Education completed with Environmental Director and associates to ensure no furniture in corridors unless it is affixed to a wall or floor. 4. The Environmental	09/09/2022

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	(d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect all residents. Findings include: Based on observation with the Environmental Assistant on 08/09/22 between 11:20 a.m. and 1:00 p.m., throughout the building there were times such as a dresser and chairs in the corridors that extended about two feet into the corridors and were not affixed to the floor or wall when tested. Based on interview at the time of the observations, the Environmental Assistant agreed there was a dresser and chairs that were not securely attached to the floor or to the wall when tested. This finding was reviewed with the Administrator and Environmental Assistant at the exit conference. 3.1-19(b)		Director/Designee will inspect corridors to ensure no furniture in corridors unless affixed to a wall or floor 3 X week for 4 weeks, 2 X week for 4 weeks, 1 X week for 4 weeks, then monthly X 3 months. Environmental/Designee will report findings to the Quality Assurance Committee for at least 6 months.	

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K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to maintain latching hardware on 1 of 7 smoke barrier doors, LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect 20 residents in two smoke compartments. Findings include: Based on observation with the Environmental Assistant on 08/09/22 at 10:30 a.m., the set of smoke barrier doors in the admin area was provided with latching hardware but failed to latch when tested due to the latch was broken and sticking out of the top of the door. Based on interview at the time of observation, the Environmental Assistant agreed the smoke doors were equipped with latching devices, but the doors did not properly latch when tested. This finding was reviewed with the Administrator and Environmental Assistant at the exit conference. 3.1-19(b)	K 0300	1. The identified smoke barrier door has been repaired to ensure proper latching. 2. 2. All residents have the potential to be affected by this alleged deficient practice. All remaining smoke barrier doors have been inspected by Environmental Director. No further issues have been noted. 3. Education completed with Environmental Director and associates regarding proper latching of smoke barrier doors. 4. The Environmental Director/Designee will inspect smoke barrier doors to ensure latching mechanisms are properly latching 3 X week for 4 weeks, 2 X week for 4 weeks, 1 X week for 4 weeks, then monthly X 3 months. Environmental/Designee will report findings to the Quality Assurance Committee for at least 6 months.	09/09/2022
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure			

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	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) 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 3 hazardous mechanical rooms which contained fuel fired equipment were separated from other spaces by smoke resistant partitions and doors. This deficient practice could affect 20 residents in one smoke compartment. Findings include:	K 0321	1.The identified holes in the boiler room door have been repaired. 2.All residents have the potential to be affected by this alleged deficient practice. All remaining hazardous area doors have been inspected by Environmental	09/09/2022

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	Based on observations with the Environmental Assistant on 08/09/22 at 11:42 a.m., the main boiler room which contain fuel fired equipment had two holes that went through the door. This condition does not allow for smoke resistive door. Based on interview at the time of the observation, the Environmental Assistant agreed there were holes in the door and the boiler room contained fuel fired equipment. This finding was reviewed with the Administrator and Environmental Assistant at the exit conference. 3.1-19(b)		Director with no further issues noted. 3.The Environmental Director was educated that mechanical rooms which contain fuel fired equipment are separated from other spaces by smoke resistant partitions and doors. These doors are not to have any areas that smoke could go through. 4.The Environmental Director/Designee will inspect smoke barrier doors for any areas which may contain holes 3 X week for 4 weeks, 2 X week for 4 weeks, 1 X week for 4 weeks, then monthly X 3 months. Environmental/Designee will report findings to the Quality Assurance Committee for at least 6 months.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial			

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	automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 #1 Based on observation and interview, the facility failed to ensure 1 of 2 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet large enough to fit all spare sprinkler heads, and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect half of the residents and staff in the facility. Findings include: Based on observation with the Environmental Assistant on 08/09/22 at 11:50 a.m., the spare sprinkler cabinet in the front riser room was not large enough to contain all sprinkler heads and prevent damage to the sprinkler heads. When the cabinet in front riser room was opened, the cabinet contained more sprinkler heads than spots available. Based on interview at the time of the observations, the Environmental Assistant agreed the cabinet was not large enough to contain all spare sprinkler heads. #2. Based on observation and interview, the	K 0353	1. Spares have been ordered for the identified sprinkler cabinet. The identified sprinkler heads in the laundry room were cleaned and debris has been removed. 2. All residents have the potential to be affected by this deficient practice. All remaining sprinkler heads has been inspected by Environmental Director no further issues have been noted. 3. Education will be completed to Environmental Director and associates regarding inspecting and cleaning of sprinkler heads. 4. The Environmental Director/Designee will inspect sprinkler heads 3 X week for 4 weeks, 2 X week for 4 weeks, 1 X week for 4 weeks, then monthly X 3 months. Environmental/Designee will report findings to the Quality Assurance Committee for at least 6 months.	09/09/2022

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	facility failed to ensure 4 of 4 sprinkler heads in the laundry were not loaded and covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff and up to 22 residents in one smoke compartment. Findings include: Based on observation with the Environmental Assistant on 08/09/22 at 12:20 p.m., four sprinkler heads in the clean laundry room were loaded with lint. Based on interview at the time of observation, the Environmental Assistant confirmed the sprinkler heads in the clean laundry room were loaded with lint. The findings were reviewed with the Administrator and Environmental Assistant at the exit conference. 3.1-19(b)			
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.			

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	18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 30 portable fire extinguishers was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation with the Environmental Assistant on 08/09/22 at 11:40 a.m., the fire extinguisher in the boiler room was missed during the annual inspection. The tag on the extinguisher had an annual inspection date of February of 2021, all other extinguishers had the date of February of 2022. Based on interview at the time of observation, the Environmental Assistant stated it is most likely the extinguisher was missed during the annual inspection.	K 0355	1.The identified Fire Extinguisher has a scheduled date of 8/31/2022 to be inspected by Safe Care for the annual inspection. 2. All residents have the potential to be affected by this alleged deficient practice. All remaining fire extinguishers have had their annual inspection. No further issues have been noted. 3. Education will be completed to Environmental Director and associates regarding fire extinguishers. They are to be inspected annually with a label securely attached that indicates the month and year maintenance was performed, which identifies the person performing the work. 4. The Environmental Director/Designee will inspect fire extinguishers on a monthly basis. Environmental/Designee will report findings to the Quality Assurance Committee for at least 6 months.	09/09/2022

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	This finding was reviewed with the Administrator and Environmental Assistant at the exit conference. 3.1-19(b)			
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 electrical panel in the Memory Care Hall was secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect staff in the Memory Care Hall. Findings include: Based on observation with the Environmental Assistant on 08/09/22 at 12:09 p.m., the electrical	K 0511	1. The identified electrical panel had a lock placed on it on 8/12/2022 2. All residents have the potential to be affected by this alleged deficient practice. All remaining electrical panels have been identified and corrected as needed. 3. Education completed with Environmental Director and associates regarding electrical panels needing to be secured from non-authorized personnel. 4. The Environmental Director/Designee will inspect electrical panels 3 X week for 4 weeks, 2 X week for 4 weeks, 1 X week for 4 weeks, then monthly X 3 months. Environmental/Designee will report findings to the Quality Assurance Committee for at least 6 months.	09/09/2022

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LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN 46805

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	panel in the Memory Care Hall was unlocked when tested. The panel included breakers to the lights, emergency lighting, and outlets in the Memory Care Hall. Based on interview at the time of observation, the Environmental Assistant stated the electrical panel will need to be locked. This finding was reviewed with the Administrator and Environmental Assistant at the exit conference. 3.1-19(b)			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 #1, Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions for 4 of 4 quarters. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on records review with the Environmental Assistant on 08/09/22 at 10:20 a.m., the following shifts did not have fire drills at unexpected times: a. All second shift (2:00 p.m. to 10:00 p.m.) fire	K 0712	1. In August Fire Drill were conducted on all three shifts at various times, which included transmission of fire alarm signal 2. All residents have the potential to be affected by this alleged deficient practice. Therefore in the Month of August three separate fire drills were done on the different shifts. For the month of September Life Care Center of Fort Wayne will be back	09/09/2022

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	drills took place around 2:00 p.m. b. All third shift (10:00 p.m. to 6:00 a.m.) fire drills took place around 11:00 p.m. Based on interview at the time of record review, the Environmental Assistant agreed fire drills for second and third shifts were not held at unexpected times. #2, Based on record review and interview, the facility failed to conduct fire drills on each shift for 1 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on records review with the Environmental Assistant on 08/09/22 at 10:20 a.m., no documentation was available to show a third shift fire drill for the second quarter of 2022 was conducted. Based on interview at the time of record review, the Environmental Assistant stated the aforementioned drill was not conducted due to the previous Maintenance Director did two second shift drills. #3. Based on record review and interview, the facility failed to ensure 1 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors.		on track for Quarterly drills done at unexpected times at least quarterly on each shift. 3. Education will be completed with Environmental Director regarding Fire Drills held at unexpected times at least quarterly on each shift and to include verification of transmission of fire alarm signal to be tested. 4. The Administrator/Designee will inspect fire drills to ensure Drills are held at unexpected times, at least quarterly on each shift and to include the verification of transmission of fire alarm signal to be tested on a monthly basis. Findings will be reported to the Quality Assurance Committee for at least 6 months.	

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	Findings include: Based on records review with the Environmental Assistant on 08/09/22 at 10:20 a.m., the form for the first quarter first shift fire drill indicated transmission of signal was not tested. The field for transmitting the signal indicated N/A(PM). Based on interview at the time of record review, the Environmental Assistant agreed the aforementioned drill indicated transmitting the signal did not happen. The findings were reviewed with the Administrator and Environmental Assistant at the exit conference. 3.1-19(b) 3.1-51(c)			
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not			

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	apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview, the facility failed to ensure combustible gases were not stored in 1 of 1 smoking areas. This deficient practice could affect staff in the smoking. Findings include: Based on observations with the Environmental Assistant on 08/09/22 at 12:36 p.m., the staff smoking area contained a propane tank sitting inside the designated smoking area. Based on interview at the time of observation, the Environmental Assistant stated the tank is used for the grill and agreed the tank was sitting inside the smoking area. This finding was reviewed with the Administrator and Environmental Assistant at the exit conference. 3.1-19(b)	K 0741	1. The identified propane tank was immediately removed from staff smoking area. 2. All residents have the potential to be affected by this alleged deficient practice. All remaining designated smoking areas were inspected for combustible gases. No further issues were noted. 3. Education completed with Environmental Director and associates regarding combustible gases are not to be stored in designated smoking areas. 4. 4. The Environmental Director/Designee will inspect designated smoking areas to ensure combustible gases are not stored in that location 3 X week for 4 weeks, 2 X week for 4 weeks, 1 X week for 4 weeks, then monthly X 3 months. Environmental/Designee will report findings to the Quality Assurance Committee for at least 6 months.	09/09/2022
K 0927 SS=F Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders			

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	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 containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) #1. Based on records review and interview, the facility failed to ensure staff was properly trained on trans-filling procedures in 1 of 1 oxygen storage room where oxygen transferring takes place. NFPA 99 2012 edition, 11.5.2.3.1 (4) the individual trans-filling the container(s) has been properly trained in the trans-filling procedures. This deficient practice could affect all residents. Findings include: Based on records review with the Environmental Assistant and Administrator on 08/09/22 at 2:18 p.m., no documentation was available for review to indicate staff that trans-fill liquid oxygen were properly trained. Based on interview at the time records review, the Administrator stated staff are trained during orientation but was unable to provide the training paperwork. #2. Based on observation and interview, the facility failed to ensure 1 of 1 doors to the oxygen trans-filling room were in accordance with 2012 NFPA 99 11.5.2.3.1(1) and NFPA 80. 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	K 0927	1. Nursing Staff trained on 8/23/2022 on trans-filling procedures of liquid oxygen The Oxygen transfilling room's door has been repaired and there are no longer visible signs of holes. 2. Residents have the potential to be affected by this alleged deficient practice, therefore nursing staff have been trained on transfilling procedures of liquid oxygen and holes have been covered. 3. Education completed with nursing staff on procedures of transfilling of liquid oxygen. This education will be provided to all new nursing staff hires. Yearly re-education has been added to the inservice calendar for the month of July to ensure annual training has been reviewed. 4. The Director of Nursing/Designee will audit new nursing staff hires to ensure education of transfilling of liquid oxygen has been completed.3 X	09/09/2022

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	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 20 residents in one smoke compartment. Findings include: Based on observations with the Environmental Assistant on 08/09/22 at 12:18 p.m., the oxygen trans-filling room had a two small holes on the outside of the fire door. Based on an interview at the time of observation, the Environmental Assistant agreed there were two holes in the fire door to the oxygen trans-filling room. The findings were reviewed with the Administrator and Environmental Assistant at the		week for 4 weeks, 2 X week for 4 weeks, 1 X week for 4 weeks, then monthly X 3 months. Director of Nursing/Designee will report findings to the Quality Assurance Committee for at least 6 months.	

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	exit conference. 3.1-19(b)			