STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155771	A. BUILDING -- B. WING	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE	1070 W JEFFERSON ST FRANKLIN, IN 46131

(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: 08/07/24 Facility Number: 001127 Provider Number: 155771 AIM Number: 200247220 At this Emergency Preparedness survey, Otterbein Franklin Senior Life Comm Res & Com Care was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 208 certified beds. At the time of the survey, the census was 141. Quality Review completed on 08/12/24 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	The creation and submission of this Plan of Correction do not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or any violation of the regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post-survey review.	
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), 485.542(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), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a),			

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

Shannon Logan | Administrator | 08/26/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155771	A. BUILDING -- B. WING	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	§491.12(a), §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 maintain 1 of 1 emergency preparedness plans that were reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of emergency preparedness program documentation with the Maintenance Manager and the Maintenance Assistant during record review from 9:10 a.m. to 12:40 p.m. on 08/07/24, emergency preparedness program documentation which was reviewed within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Manager agreed emergency preparedness program documentation was not documented as being reviewed within the most recent twelve month period at the time of the survey. These findings were reviewed with the Maintenance Manager during the exit conference.	E 0004	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. Disaster Plan has been developed and in place; it was reviewed on 7/24/2024. Maintenance Supervisor did not provide plan during surveyor visit. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Red binders labeled Emergency Preparedness will be readily available, with all updated material in the following offices: Executive Director, Administrator, DON, and Maintenance. These binders will be updated each quarter in QAPI. An audit to ensure binders are updated will be completed once a month for six months by the Administrator. **How will the corrective**	08/23/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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			action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Any identified deficiencies will be corrected upon discovery and reviewed by the QAPI committee for further recommendation. **By what date the systemic changes for each deficiency will be completed?** 8/23/2024	
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.542(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk			

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	155771	A. BUILDING -- B. WING	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain			

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	an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach which was reviewed within the most recent twelve month period and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants. Findings include: Based on review of emergency preparedness program documentation with the Maintenance Manager and the Maintenance Assistant during record review from 9:10 a.m. to 12:40 p.m. on 08/07/24, a documented facility-based and community-based risk assessment reviewed by the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Manager agreed a documented facility-based and community-based risk assessment reviewed by the facility within the most recent twelve month period was not available for review at the time of the survey.	E 0006	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. Disaster Plan has been developed and in place; it was reviewed on 7/24/2024. Maintenance Supervisor did not provide plan during surveyor visit. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Red binders labeled Emergency Preparedness will be readily	08/23/2024

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	These findings were reviewed with the Maintenance Manager during the exit conference.		available, with all updated material in the following offices: Executive Director, Administrator, DON, and Maintenance. These binders will be updated each quarter in QAPI. An audit to ensure binders are updated will be completed once a month for six months by the Administrator. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Any identified deficiencies will be corrected upon discovery and reviewed by the QAPI committee for further recommendation. **By what date the systemic changes for each deficiency will be completed?** 8/23/2024	
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), 485.542(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), §485.542(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			

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	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 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.			

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	*[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 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 review and update its emergency preparedness policies annually. 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 occupants. Findings include: Based on review of emergency preparedness program documentation with the Maintenance Manager and the Maintenance Assistant during record review from 9:10 a.m. to 12:40 p.m. on 08/07/24, emergency preparedness policies and procedures reviewed within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Manager agreed emergency preparedness policies and procedures reviewed within the most recent twelve month period was not available for review at the time of the survey. These findings were reviewed with the Maintenance Manager during the exit conference.	E 0013	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. Disaster Plan has been developed and in place; it was reviewed on 7/24/2024. Maintenance Supervisor did not provide plan during surveyor visit. **What measures will be put into place and what systemic**	08/23/2024

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			changes will be made to ensure that the deficient practice does not recur? Red binders labeled Emergency Preparedness will be readily available, with all updated material in the following offices: Executive Director, Administrator, DON, and Maintenance. These binders will be updated each quarter in QAPI. An audit to ensure binders are updated will be completed once a month for six months by the Administrator. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Any identified deficiencies will be corrected upon discovery and reviewed by the QAPI committee for further recommendation. **By what date the systemic changes for each deficiency will be completed?** 8/23/2024	
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), 485.542(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), §485.542(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c),			

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	§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 which 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 emergency preparedness program documentation with the Maintenance Manager and the Maintenance Assistant during record review from 9:10 a.m. to 12:40 p.m. on 08/07/24, documentation for a complete emergency preparedness communication plan reviewed by the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Manager agreed documentation for a complete emergency preparedness communication plan reviewed by the facility within the most recent twelve month period was not available for review at the time of the survey. These findings were reviewed with the Maintenance Manager during the exit conference.	E 0029	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. Disaster Plan has been developed and in place; it was reviewed on 7/24/2024. Maintenance Supervisor did not provide plan during surveyor visit. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Red binders labeled Emergency Preparedness will be readily available, with all updated material in the following offices: Executive Director, Administrator, DON, and	08/23/2024

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			Maintenance. These binders will be updated each quarter in QAPI. An audit to ensure binders are updated will be completed once a month for six months by the Administrator. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Any identified deficiencies will be corrected upon discovery and reviewed by the QAPI committee for further recommendation. **By what date the systemic changes for each deficiency will be completed?** 8/23/2024	
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), 485.542(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), §485.542(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, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155771	A. BUILDING -- B. WING	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE	1070 W JEFFERSON ST FRANKLIN, IN 46131

(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
	§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 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			

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	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 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. Findings include: Based on review of emergency preparedness program documentation with the Maintenance Manager and the Maintenance Assistant during record review from 9:10 a.m. to 12:40 p.m. on 08/07/24, the facility's emergency preparedness training and testing program documentation was not reviewed within the most recent twelve month period. Based on interview at the time of record review, the Maintenance Director agreed the facility's emergency preparedness training and testing program documentation was not reviewed within the most recent twelve month period. These findings were reviewed with the Maintenance Manager during the exit conference.	E 0036	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. Disaster Plan has been developed and in place; it was reviewed on 7/24/2024. Maintenance Supervisor did not provide plan during surveyor visit. **What measures will be put into place and what systemic changes will be made to**	08/23/2024

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			ensure that the deficient practice does not recur? Red binders labeled Emergency Preparedness will be readily available, with all updated material in the following offices: Executive Director, Administrator, DON, and Maintenance. These binders will be updated each quarter in QAPI. An audit to ensure binders are updated will be completed once a month for six months by the Administrator. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Any identified deficiencies will be corrected upon discovery and reviewed by the QAPI committee for further recommendation. **By what date the systemic changes for each deficiency will be completed?** 8/23/2024	
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: 08/07/24 Facility Number: 001127 Provider Number: 155771	K 0000	The creation and submission of this Plan of Correction do not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or any violation of the regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of	

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	AIM Number: 200247220 At this Life Safety Code Survey, Otterbein Franklin Senior Life Comm Res & Com Care 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. Otterbein Franklin Senior Life Comm Res & Com Care consists of four separate but connected buildings constructed at four different times: Building 01 an NCC facility built in 1957, is a three story sprinklered building of Type I (332) construction with a basement; Building 02 built in 1980 is a three story sprinklered building of Type I (332) construction with a basement; Building 03 built in 1992 is a one story sprinklered building of Type I (332) construction with a basement; and Building 04 built in 2000 is a three story sprinklered building of Type I (332) construction. Because all buildings are of the same type of construction, the facility was surveyed as one building. The facility has a fire alarm system with smoke detection in the corridors and all areas open to the corridor. In Building 02, 47 battery operated detectors were provided in resident rooms in Health Center 2 and Health Center 3. All other resident rooms in Building 02 are provided with hard wired smoke detectors. In Building 03 and Building 04, hard wired smoke detectors are installed in all resident rooms except in Room 23 in Building 03. The healthcare portion of the facility has a capacity of 208 and had a census of 141 at the time of this survey. All areas where residents have customary access		Credible Allegation of Compliance and requests a desk review in lieu of a post-survey review.	

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	were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 08/12/24			
K 0232 SS=E 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 4 of over 4 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. (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.	K 0232	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. All bench seats and wooden chairs were removed from the corridors by the maintenance staff on 8/13/2024. **What measures will be put into place and what systemic changes will be made to**	08/23/2024

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	(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 over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Manager during a tour of the facility from 1:15 p.m. to 3:25 p.m. on 08/07/24, one bench seat was stored in the corridor up against the wall outside Room 217, Room 307, Room 316, Room 324 and Room 353 in Building 2 and Building 4 and were not affixed to the floor or to the wall. Two wooden chairs were also stored next to the bench seat outside Room 353. The furniture extended eighteen inches into the eight foot wide corridor. In addition, one bench seat was stored in the corridor up against the wall outside Room 3B, Room 5B and Room 9 in Murphy's Special Care in Building 3 and were not affixed to the floor or to the wall. Based on interview at the time of the observations, the Maintenance Manager agreed furniture was stored in the corridor at the aforementioned locations and was not affixed to the floor or to the wall. These findings were reviewed with the Maintenance Manager during the exit conference. 3.1-19(b)		**ensure that the deficient practice does not recur?** Audits of corridors will be conducted by the Maintenance Manager and/or his designee weekly for four weeks and then monthly for three months. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Maintenance Director is responsible for ensuring audits are completed. Audit will be reviewed by the QA committee. Once initial audit is completed and 100% compliance is met, the committee may choose to discontinue the audit. **By what date the systemic changes for each deficiency will be completed?** 8/23/2024	

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K 0341 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on record review, observation and interview; the facility failed to ensure 1 of 1 fire alarm systems was installed in accordance with 19.3.4.1. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 17.7.3.2.1 states spot-type smoke detectors shall be located on the ceiling not less than 4 inches from the sidewall or on the sidewalls between 4 inches and 12 inches from the ceiling. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the second floor elevator machine room in Building 2. Findings include: Based on review of the fire alarm system inspection contractor's "Suppression Aerosol Inspection Report" documentation dated 07/26/24 with the Maintenance Manager and the Maintenance Assistant during record review from 9:10 a.m. to 12:40 p.m. on 08/07/24, one fire alarm system smoke detector is not properly installed.	K 0341	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. The Fire Alarm System Contractor was at the facility on 7/26/2024 to check broken detector. It was determined that parts needed to be ordered and the contractor was	08/23/2024

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	The "Deficiencies" section of the 07/26/24 inspection report stated "Smoke Detector - 2nd floor- Elevator Machine Room Deficiency Found: The smoke detector head functioned properly but the base is broken off the electrical box, I tried reattaching it to the box but a piece of plastic was broke off inside the base. A new smoke detector base needs to be mounted to the box". Based on interview at the time of record review, the Maintenance Manager stated the fire alarm system inspection contractor is scheduled to make the necessary repairs on August 13th. Based on observations with the Maintenance Manager during a tour of the facility from 1:15 p.m. to 3:25 p.m. on 08/07/24, the smoke detector for the facility's fire alarm system installed in the second floor elevator machine room was detached from its base. These findings were reviewed with the Maintenance Manager during the exit conference. 3.1-19(b)		scheduled for a revisit on 8/13/2024. On 8/13/2024, contractor completed the repairs to the broken detector. The unit was working properly; however, the base of the alarm was broken and in need of repair, which was scheduled. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** An audit will be completed by the Maintenance Supervisor and/or his designee, once a week for four weeks to ensure all smoke detectors are secured and working properly. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Any identified deficiencies will be corrected upon discovery and reviewed by the QAPI committee for further recommendation. **By what date the systemic changes for each deficiency will be completed?** 8/23/2024	
K 0907 SS=D Bldg. 01	NFPA 101 Gas and Vacuum Piped Systems - Maintenance Pr Gas and Vacuum Piped Systems - Maintenance Program Medical gas, vacuum, WAGD, or support gas			

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	systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99)			
	Based on record review and interview, the facility failed to maintain the facility's piped gas systems in accordance with NFPA 99, Health Care Facilities Code, 2012 Edition. This deficient practice could affect three residents should the facility's pipe gas system not be operational. Findings include: Based on review of the piped gas system inspection contractor's "Medical Gas Annual Inspection" documentation dated 06/13/24 with the Maintenance Manager and the Maintenance Assistant during record review from 9:10 a.m. to 12:40 p.m. on 08/07/24, annual inspection documentation for the facility's piped gas systems within the most recent twelve month period indicated a total of three patient outlet terminals failed testing. The right vacuum outlet terminal in Room 201 was listed as "outlet damaged". The right vacuum outlet terminal in Room 306 was listed as "low flow". The 1st oxygen outlet terminal in Room 212 was listed as "leaks without adapter inserted". Based on interview at the time of record review, the Maintenance Manager	K 0907	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. On 6/13/2024, the contractor for the Medical Gas Annual Inspection noted three areas that needed repair. A quote for repair was submitted to the Executive Director for approval. Contractor will be at the facility by 9/30/2024 to complete repairs.	09/30/2024

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	agreed annual inspection documentation for the facility's piped gas systems indicated a total of three resident sleeping room outlet terminals needed repair. These findings were reviewed with the Maintenance Manager during the exit conference. 3.1-19(b)		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** On annual inspections, any deficiency found will be addressed immediately. An audit will be completed by the Maintenance Manager and/or his designee once a month for six months to ensure proper functioning. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Any identified deficiencies will be corrected upon discovery and reviewed by the QAPI committee for further recommendation. **By what date the systemic changes for each deficiency will be completed?** 9/30/2024	
K 9999 Bldg. 01	State Findings 3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS 3.1-19(a) The facility must be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel, and the public.	K 9999	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the**	08/30/2024

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	This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to provide smoke detectors in 1 of over 50 resident sleeping rooms. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of Room 23 in Building 3. Findings include: Based on observations with the Maintenance Manager during a tour of the facility from 1:15 p.m. to 3:25 p.m. on 08/07/24, all resident sleeping rooms in the facility were equipped with a smoke detector except resident sleeping Room 23 in Building 3. A ceiling mounted ring to affix a smoke detector to the ceiling was noted in the room but no smoke detector was mounted in the mounting ring. Based on interview at the time of the observations, the Maintenance Manager agreed resident sleeping Room 23 was not currently provided with a smoke detector. These findings were reviewed with the Maintenance Manager during the exit conference. 3.1-19(a)		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. The contractor will be in by 8/30/2024 to ensure the smoke detector is secured in place. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Audits to ensure all smoke detectors are mounted and secured will be completed by the Maintenance Supervisor and/or his designee daily for one week, three times a week for one week, and then twice weekly for two weeks. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Any identified deficiencies will be corrected upon discovery and reviewed by the QAPI committee for further recommendation. **By what date the systemic changes for each deficiency will be completed?** 8/30/2024	