STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING -- B. WING	05/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCLIFF HEALTH & REHABILITATION CENTER	5024 WESTERN AVENUE SOUTH BEND, IN 46619

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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: 05/10/22 Facility Number: 013420 Provider Number: 155831 AIM Number: 201293620 At this Emergency Preparedness survey, Briarcliff Health and Rehabilitation 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 111 certified beds. At the time of the survey, the census was 88. Quality Review completed on 05/17/22	E 0000	**K000** Attached is the plan of correction for the Life Safety Code with Emergency Preparedness K000 Survey conducted at Briarcliff Health & Rehabilitation May 10, 2022. The facility is respectfully requesting desk review regarding this survey.	
E 0004 SS=C 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), §494.62(a). The [facility] must comply with all applicable			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	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. .			
	Based on record review and interview, the facility failed to review and update the	E 0004	E004 1. The facility has a	06/17/2022

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	Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 9:45 a.m. and 12:15 p.m., the EEP lacked a cover page, and no date could be found to show the EPP was reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director stated the EEP was reviewed recently but during the survey no documentation was provided indicating the EPP was updated within the last year. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m.		written/documented Emergency Preparedness program that has been implemented and will be reviewed and updated annually to assure compliance. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff at the mandatory inservice. An annual review and update will be scheduled to assure compliance. 4. The Risk Manager/designee will report education dates to new hires and all staff to the QAPI committee to assure that facility remains in compliance.	
E 0006 SS=C 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), 485.625(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)			

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	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), §485.625(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 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			

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	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 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, including missing residents 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	E 0006	E006 1. The facility has a written/documented Emergency Preparedness program that is based on a risk-assessment using an all-hazards approach specific to the geographic location of the facility and is in compliance with the plan. 2. The facility has identified all residents as having the potential to	06/17/2022

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	deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 9:45 a.m. and 12:15 p.m., no documentation was available to show that the Long Term Care Facility was based on and included a documented facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and included strategies for addressing emergency events identified by the risk assessment. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m.		be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff 4. The Risk Manager/designee will report new hire and staff education dates to the QAPI committee to assure that facility remains in compliance.	
E 0013 SS=C 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).			

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	(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 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			

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	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 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 the Emergency Preparedness Plan's (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 9:45 a.m. and 12:15 p.m., the EEP lacked a cover page, and no date could be found to show the EEP's Policies and Procedures was reviewed and updated within the last year. Based on an interview during records	E 0013	E013 1. The facility has an Emergency Preparedness program. The facility has policies and procedures that were developed based on the facility and community-based risk-assessment, and on the communication plan utilizing an all-hazards approach that is specific to the geographic location of the facility. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on	06/17/2022

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	review, the Maintenance Director stated the EEP was reviewed recently but during the survey no documentation was provided indicating the EEP's Policies and Procedures was updated within the last year. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m.		each nursing unit; all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff 4. The Risk Manager/designee will report on her education to new hires and all staff to the QAPI committee to assure that facility remains in compliance	
E 0018 SS=C Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(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			

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	and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, 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. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other			

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	location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, 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 OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b)(2). This deficient practice could affect all occupants, Findings include: Based on records review and interview with the Administrator in Training, Director of	E 0018	E018 1. The facility has an Emergency Preparedness program. The program has a tracking system to document locations of patients and staff as a part of the policies and procedures. This includes a current face sheet file located in the Risk Managers office to assure efficient, current tracking of residents/staff. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on	06/17/2022

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	Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 9:45 a.m. and 12:15 p.m., a policy and procedure that includes a system to track the location of sheltered residents in the LTC facility's care during and after an emergency was provided, but the policy did not provide a system to track the location for on-duty staff. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m.		each nursing unit; all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff and will maintain current face sheets for each resident at all times for emergency readiness. 4. The Risk Manager will review her new hire and staff education as well as her update of the face sheet file at the quarterly QAPI meeting to assure that facility remains in compliance.	
E 0020 SS=F 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			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	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. (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			

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	155831	A. BUILDING -- B. WING	05/10/2022

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BRIARCLIFF HEALTH & REHABILITATION CENTER	5024 WESTERN AVENUE SOUTH BEND, IN 46619

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	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 416.54(c)(1). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 9:45 a.m. and 12:15 p.m., the provided EPP policy and procedures documentation did not include a comprehensive plan for the safe evacuation of residents. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m.	E 0020	E020 1. The facility has an Emergency Preparedness program. The program includes policies and procedures for safe evacuation from the facility including all of the required elements of the process. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit; all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff and will maintain current face sheets for each resident at all times for emergency readiness. 4. The Risk Manager will review her new hire and staff education as well as her update of the face sheet file at the quarterly QAPI meeting to assure that facility remains in compliance.	06/17/2022
E 0029 SS=C	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c),			

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Bldg. --	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 failed to review and update the Emergency Preparedness Plan's (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 9:45 a.m. and 12:15 p.m., the EEP lacked a cover page, and no date could be found to show the EEP's Communication Plan dures was reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director stated the EEP was reviewed recently but during the survey no documentation was provided indicating the EEP's Communication Plan was updated within the last year.	E 0029	1. The facility has an Emergency Preparedness program. The program includes a written communication plan that has been reviewed by the committee and scheduled for an annual review. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit; all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff. 4. Risk Manager will inform QAPI committee of any changes in the communication should they occur between annual reviews to assure that facility remains in	06/17/2022

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	This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m.		compliance.	
E 0030 SS=C Bldg. --	403.748(c)(1), 416.54(c)(1), 418.113(c)(1), 441.184(c)(1), 482.15(c)(1), 483.475(c)(1), 483.73(c)(1), 484.102(c)(1), 485.625(c)(1), 485.68(c)(1), 485.727(c)(1), 485.920(c)(1), 486.360(c)(1), 491.12(c)(1), 494.62(c)(1) Names and Contact Information §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(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]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians			

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	(iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the			

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	following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).			
	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (1) Names and contact information for the following: (i) Staff (ii) Entities providing services under arrangement (iii) Patients' physicians (iv) Volunteers in accordance with 42 CFR 483.73(c)(1). This deficient practice could	E 0030	1. The facility has an Emergency Preparedness program. The program includes a written communication plan that includes all the required facility contacts and has been reviewed by the committee and scheduled for an annual review.	06/17/2022

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	affect all occupants. Findings include: Based on records review and interview with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 9:45 a.m. and 12:15 p.m., the emergency preparedness plan communication plan was incomplete. The emergency preparedness plan did not include contact information for current staff, it included contact information for staff who no longer work at the facility and omitted key essential personnel who now are employed at the facility. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m.		2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit; all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff. 4. Risk Manager will inform QAPI committee of any changes in the communication should they occur between annual reviews to assure that facility remains in compliance.	
E 0031 SS=C Bldg. --	403.748(c)(2), 416.54(c)(2), 418.113(c)(2), 441.184(c)(2), 482.15(c)(2), 483.475(c)(2), 483.73(c)(2), 484.102(c)(2), 485.625(c)(2), 485.68(c)(2), 485.727(c)(2), 485.920(c)(2), 486.360(c)(2), 491.12(c)(2), 494.62(c)(2) Emergency Officials Contact Information §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2),			

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	§494.62(c)(2). [(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]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency.			
	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff (ii) The State	E 0031	E031 1. The facility has an Emergency Preparedness program. The program includes a written communication plan that includes all of the required facility contacts	06/17/2022

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	Licensing and Certification Agency (iii) The Office of the State Long-Term Care Ombudsman (iv) Other sources of assistance in accordance with 42 CFR 483.73(c) (2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 9:45 a.m. and 12:15 p.m., the emergency preparedness communication provided plan failed to include contact information for (i) Federal, State, tribal, regional, or local emergency preparedness staff (ii) The State Licensing and Certification Agency (iii) The Office of the State Long-Term Care Ombudsman (iv) Other sources of assistance. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m.		as well as all of the required Emergency Officials contact information and has been reviewed by the committee and scheduled for an annual review. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit; all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff. 4. Risk Manager will inform QAPI committee of any changes in the communication should they occur between annual reviews to assure that facility remains in compliance.	
E 0033 SS=F Bldg. --	403.748(c)(4)-(6), 416.54(c)(4)-(6), 418.113(c)(4)-(6), 441.184(c)(4)-(6), 482.15(c)(4)-(6), 483.475(c)(4)-(6), 483.73(c)(4)-(6), 484.102(c)(4)-(5), 485.625(c)(4)-(6), 485.68(c)(4), 485.727(c)(4), 485.920(c)(4)-(6), 491.12(c)(4), 494.62(c)(4)-(6) Methods for Sharing Information			

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§403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.102(c)(4)-(5), §485.68(c)(4), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6).

[(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]. The communication plan must include all of the following:

(4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care.

(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)]

(6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4).

*[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care,

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	based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).			
	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (4) A method for sharing information and medical documentation for residents under the LTC facility's care, as necessary, with other health care providers to maintain the continuity of care; (5) A means, in the event of an evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); (6) A means of providing information about the general condition and location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4) in accordance with 42 CFR 483.73(c)(4). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 9:45 a.m. and 12:15 p.m., the emergency preparedness plan provided did not include a communication plan with a method for sharing information and medical documentation for residents under the LTC facility's care, as necessary, with other health care providers to maintain the continuity of care.	E 0033	1. The facility has an Emergency Preparedness program. The program includes a method for sharing information and medical documentation for patients under the facilitys care, as necessary, with other health providers to maintain the continuity of care. The facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients by reviewing the communication plan. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit, Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff. 4. Risk Manager will inform QAPI committee of any changes in the plan should they occur between annual reviews to assure that facility remains in compliance	06/17/2022

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	This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m.			
E 0035 SS=F Bldg. --	483.475(c)(8), 483.73(c)(8) LTC and ICF/IID Sharing Plan with Patients §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC 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 annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID 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. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. Based on record review and interview, the facility failed to ensure the emergency preparedness plan (EPP) includes a method for sharing information from the emergency plan	E 0035	E035 1. The facility has an Emergency Preparedness program communication plan that includes	06/17/2022

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCLIFF HEALTH & REHABILITATION CENTER	5024 WESTERN AVENUE SOUTH BEND, IN 46619

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 9:45 a.m. and 12:15 p.m., the Emergency Preparedness Binder provided did not address a method for sharing information contained within the EPP Binder that the facility deems appropriate with residents, their families or representatives. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m.		a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with residents or clients and their families or representatives by reviewing the plan. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit; all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff. 4. Risk Manager will inform QAPI committee of any changes in the plan should they occur between annual reviews to assure that facility remains in compliance.	
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),			

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	§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 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			

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	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.			
	1. Based on record review and interview, the facility failed reviewed and updated the Emergency Preparedness Plan's (EPP) Training and Testing Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 9:45 a.m. and 12:15 p.m., the EEP lacked a cover page, and no date could	E 0036	E036 1. The facility has an Emergency Preparedness plan has a written testing and training program. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit; all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all	06/17/2022

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	be found to show the EPP's Training and Testing Plan was reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director stated the EEP was reviewed recently but during the survey no documentation was provided indicating the EPP's Training and Testing Plan was updated within the last year. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. 2. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that is based on the emergency plan accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 9:45 a.m. and 12:15 p.m., the provided Emergency Preparedness Plan (EPP) did not contain a training and testing program. This finding was acknowledged by the Administrator in Training, Director of		staff. 4. Risk Manager will inform QAPI committee of any changes in the plan should they occur between annual reviews to assure that facility remains in compliance.	

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	Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m.			
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures.			

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	(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years.			

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	(iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency			

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	preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers,			

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	consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.			
	Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility.	E 0037	E037 1. The facility has an Emergency Preparedness plan that provides the signatures of attendance for the the initial emergency preparedness training as well as a calendar scheduled annual review, update and training each year. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit; all staff has been educated on the plan. Risk	06/17/2022

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	Findings include: Based on records review and interview with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 9:45 a.m. and 12:15 p.m., no documentation of annual EEP training and no documentation to show staff could demonstrate knowledge of the EPP was available for review. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m.		Manager will provide training to new hires and will present a quarterly review of the plan to all staff. 4. Risk Manager will inform QAPI committee of any changes in the plan should they occur between annual reviews to assure that facility remains in compliance.	
E 0039 SS=C Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:			

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	(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):]			

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	(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or			

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	(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual,			

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BRIARCLIFF HEALTH & REHABILITATION CENTER	5024 WESTERN AVENUE SOUTH BEND, IN 46619

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	facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual			

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natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.

*[For LTC Facilities at §483.73(d):]
(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.
(B) If the [LTC facility] facility experiences an actual natural or man-made emergency

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	that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its			

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	next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.			

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	(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop			

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	exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. The ICF/IID facility must do all of the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based	E 0039	E039 1. The facility has an Emergency Preparedness plan includes the annual tabletop and full-scale exercise. 2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit; all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff. 4. Risk Manager will inform QAPI committee of any changes in the plan should they occur between annual reviews to assure that	06/17/2022

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	functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 9:45 a.m. and 12:15 p.m., the facility lacked documentation of an actual emergency or a required full-scale exercise. The facility provided evidence of COVID 19 being used as an exercise of choice (table-top). This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m.		facility remains in compliance.	

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E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.			

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	482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012.			

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	(iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 9:45 a.m. and 12:15 p.m., the facility provided documentation for testing of the emergency generator, however, could not provide documentation of consistent monthly load testing.	E 0041	E041 1. The facility has an Emergency Preparedness that has: a) the required emergency and standby power systems to meet the requirements of the facilitys emergency plan and corresponding policies and procedures b) emergency power systems or plans in place to maintain safe operations while sheltering in place c) maintains an onsite fuel source in accordance with NFPA 110 for their generator d) has a plan for how to keep the generator operational during an emergency, unless the facility plans to evacuate	06/17/2022

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	This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m.		2. The facility has identified all residents as having the potential to be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit; all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff. 4. Risk Manager will inform QAPI committee of any changes in the plan should they occur between annual reviews to assure that facility remains in compliance.	
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: 05/10/22 Facility Number: 013420 Provider Number: 155831 AIM Number: 201293620 At this Life Safety Code survey, Briarcliff Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.	K 0000	**K000** Attached is the plan of correction for the Life Safety Code with Emergency Preparedness K000 Survey conducted at Briarcliff Health & Rehabilitation May 10, 2022. The facility is respectfully requesting desk review regarding this survey.	

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	This one-story facility with a basement was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, all areas open to the corridor and hard-wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 111 and had a census of 88 at the time of this survey. At the time of this survey, Halls 100 and 200 were unoccupied and experiencing significant and comprehensive remodeling. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 05/17/22			
K 0211 SS=F 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 all corridor means of egresses, were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm).	K 0211	**K211** What corrective actions will be accomplished for those residents found to have affected by the deficient practice; **Boxes identified will be moved to a designated storage space.** How the facility will identify other resident having the potential to be affected by the same deficient	06/17/2022

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	(b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice affects all residents in the facility. Findings include: Based on observation and interview during the facility tour with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 12:15 p.m. and 3:10 p.m., the 600-hall dayroom area at the end of the corridor there were at least 12 large boxes being stored. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. 3.1-19(b)		practice and what corrective action will be taken; **Facility will be toured to check for additional boxes in corridors and hallways and correct any identified deficiencies. None found.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **Inservice will be done with maintenance and central supply personnel to ensure boxes are not stored in corridors and hallways throughout the facility. Maintenance/designee will do rounds once a week for 8 weeks to ensure no boxes are present.** How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place; **Maintenance/designee will present 3 months of audit results to QAPI committee and progress will be assessed and adjusted as needed.**	
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall			

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	not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to 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			

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	contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	1. Based on observation and interview, the facility failed to ensure the means of egress through courtyard 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 and staff at the facility. Findings include: Based on observation and interview during the facility tour with the Administrator in Training, Director of Maintenance, Maintenance Assistant	K 0222	**K222 -1** What corrective actions will be accomplished for those residents found to have affected by the deficient practice; **Padlocks to gates in the surrounding courtyards will be placed such that they** **are accessible from the side facing the building for emergency exit purposes.** How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken; **All combination locks on the**	06/17/2022

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	and Director of Maintenance from another facility on 05/10/22 between 12:15 p.m. and 3:10 p.m., the gates exiting from the facilities two courtyards (Therapy Courtyard and Courtyard with the Gazebo) to the public way, were equipped with combination locks. When random staff were asked if they knew the combination 3 of 3 staff were not familiar, stating they would just ask someone. Additionally, the courtyard gate from the Main Therapy Courtyard to the public way was locked with a combination lock on the outside of the gate and was not accessible from inside the courtyard. The Assistant Maintenance Director stated that was done so that when the mower people arrived they could come in to mow without collecting someone from the facility to let them in. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. 2. Based on observation and Interview, the facility failed to ensure all delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions:		**exterior will be tested to ensure proper code is known and posted appropriately.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **Inservice will be done with all staff regarding correct codes to combination locks and codes will be posted at nurse's stations. Maintenance will interview 5 staff × 8 weeks to ensure successful education(s) of staff.** How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place; **Maintenance/designee will present 3 months of audit results to QAPI committee and progress will be assessed and adjusted as needed.** **K222-2** What corrective actions will be accomplished for those residents found to have affected by the deficient practice; **Egress door with delayed lock release mechanism near the salon has been transitioned to a standard code-input locking mechanism by removing signage.** How the facility will identify other resident having the potential to be	

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	(a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect 35 residents. Findings include: Based on observation and interview during the facility tour with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 12:15 p.m. and 3:10 p.m., facilities exit door to the gazebo courtyard, near the Salon, equipped with a 15 second delayed egress failed to work when tested 3 times by the Assistant Maintenance Director. When the exit doors were tested the irreversible process to release the lock was not initiated. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. 3.1-19(b)		affected by the same deficient practice and what corrective action will be taken; **All egress doors with delayed lock releases will be tested and repaired.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **Maintenance staff will be educated on proper functioning of delayed-release locks and vendor contact for repair.** **Egress doors will be audited once a week × 8 weeks.** How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place; **Maintenance/designee will present 3 months of audit results to QAPI committee and progress will be assessed and adjusted as needed.**	

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K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7			
	Based on observation and interview, the facility failed to ensure all exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect 25 residents. Findings include: Based on observation and interview during the facility tour with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 12:15 p.m. and 3:10 p.m., the exit discharge from the 300-Hall, had large cracks in the concrete where it met the blacktop and was uneven with approximately a 2-inch height variation creating a trip hazard. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative	K 0271	K271 What corrective actions will be accomplished for those residents found to have affected by the deficient practice; **Exit discharge from 300-hall will be leveled-out or ramped and the cracks will be filled to even-out surface.** How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken; **All exit discharges will be checked to ensure they are level and free of cracks.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **All exit discharges will be checked to ensure they are level and free of cracks.** How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place;	06/17/2022

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	present at 4:15 p.m. 3.1-19(b)		**Maintenance/designee will present 3 months of audit results to QAPI committee and progress will be assessed and adjusted as needed.**	
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 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, 17.7.4.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 5 staff on the 200 hall. Findings include: Based on observation and interview during the facility tour with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 12:15 p.m. and	K 0341	**K341** What corrective actions will be accomplished for those residents found to have affected by the deficient practice; **Smoke alarms in 200-hall will be placed at a uniform height.** How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken; **All smoke detections systems will be inspected throughout the facility for additional unevenly places units.**	06/17/2022

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	3:10 p.m., the smoke detectors located on the 200 hallway were attached in unequal location. Some were attached to the concrete ceiling and others were attached to the drop ceiling. The entire 200 hallway was under remodel/renovation and missing most of the drop ceiling tiles. The varying height installation of the smoke appliances could impede the system's ability to report to the panel accurately in a smoke event. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. 3.1-19(b)		What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **Audits of instances of unevenly placed smoke detectors will be done by maintenance /designee once a week × 8 weeks to ensure compliance.** How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place; **Maintenance/designee will present 3 months of audit results to QAPI committee and progress will be assessed and adjusted as needed.**	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be	K 0345	**K345** What corrective actions will be accomplished for those residents found to have affected by the	06/17/2022

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	installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 9:45 a.m. and 12:15 p.m., no documentation was provided for review showing the annual and semi-annual fire alarm report. No Fire Alarm system testing reports were available for review for days prior to January 2020 and the onset or the COVID 19 Pandemic to demonstrate that the Fire Alarm system was being inspected prior to the COVID Pandemic. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. 3.1-19(b)		deficient practice; **Fire alarm testing were and will be performed, and reports will be added to a revised and up-to-date Life Safety binder with clearly marked dates on-file.** How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken; **Review and organization of previous year of fire alarm testing will be done.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **Maintenance staff will be trained on putting together and keeping a life safety binder with readily viewable paper copies. Life Safety book will be audited once a week × 3 months, once a month × 6 months, and quarterly afterwards to keep compliance.** How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place; **Maintenance/designee will present 3 months of audit results to QAPI committee and progress will be assessed and adjusted as needed.**	

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K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Sprinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)			
	Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in accordance with 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect up to 3 staff.	K 0351	**K351** What corrective actions will be accomplished for those residents found to have affected by the deficient practice; **500-hall janitors closet wiring conduit will be moved out of the plane in which it obstructs the operation of the sprinkler system.** How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken; **All other sprinkler systems will**	06/17/2022

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	Findings include: Based on observation and interview during the facility tour with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 12:15 p.m. and 3:10 p.m., the 500 Hall Janitors Closet equipped with 1 sidewall sprinkler head, the aforementioned sprinkler head was obstructed with wire conduit installed in front of the sprinkler head, within 2-3 inches. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned sprinkler head was obstructed. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. 3.1-19(b)		**be checked for obstructions which hinder operation.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **Maintenance/designee will audit facility for any obstructed sprinkler heads and fix any units affected.** How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place; **Maintenance/designee will present 3 months of audit results to QAPI committee and progress will be assessed and adjusted as needed.**	
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 1. Based on observation and interview, the facility failed to ensure all portable fire	K 0355	**K355(1)** What corrective actions will be	06/17/2022

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	extinguishers were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice was not in a resident care area but could affect staff in the basement area. Findings include: Based on observation and interview during the facility tour with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 12:15 p.m. and 3:10 p.m., an ABC portable fire extinguisher in the basement maintenance area was sitting on the floor and was unsecured. Based on interview at the time of observation, the Maintenance Director stated it was a spare. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. 2. Based on observation and interview, the facility failed to inspect all portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers,		accomplished for those residents found to have affected by the deficient practice; **The identified fire extinguisher will be affixed to the wall in an appropriate manner or will be disposed of appropriately.** How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken; **Facility at large will be toured for additional fire extinguisher not mounted to the wall and will be corrected in similar fashion.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **Maintenance/designee will check facility for non-compliant fire extinguishers once a week × 4 weeks and correct any findings.** How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place; **Maintenance/designee will present 3 months of audit results to QAPI committee and progress will be assessed and adjusted as needed.** **K355(2)** What corrective actions will be accomplished for those residents found to have affected by the	

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	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 (6) Indicator for nonrechargeable extinguishers using pushto-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 staff in the 200 hall. Findings include: Based on observation and interview during the		deficient practice; **Fire extinguisher on 200-hall will be inspected monthly.** How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken; **All fire extinguishers will continue to be inspected and replaced/recharged, if necessary, monthly.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **Maintenance/designee will formulate a map of all fire extinguishers in facility using a floor plan and use the floor plan as a guide to audit facility extinguishers. Map will be updated quarterly to ensure no new extinguishers are missing inspection.** How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place; **Maintenance/designee will present 3 months of audit results to QAPI committee and progress will be assessed and adjusted as needed.**	

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	facility tour with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 12:15 p.m. and 3:10 p.m., the monthly and annual inspection tag on the ABC fire extinguisher located in the 200 Hall lacked documentation of recent monthly inspections. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. 3.1-19(b)			
K 0363 SS=E 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.			

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	Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure all corridor doors would resist the passage of smoke. This deficient practice could affect 15 residents. Findings include: Based on observation and interview during the facility tour with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 12:15 p.m. and 3:10 p.m., the following corridor doors had holes which penetrated completely through the door:	K 0363	**K363** What corrective actions will be accomplished for those residents found to have affected by the deficient practice; **The identified four doors will both have correct hardware installed and be adjusted or repaired for a proper seal.** How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken; **All doors will be inspected to**	06/17/2022

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	A) A 1/4 inch hole through the door above the latching hardware in the Director of Nursing Office. B) Two 1/4 inch holes through the door above the latching hardware in the Activities Storage area. C)) A 3-4 inch hole through the door where latching hardware was missing on the 600 Hall Janitors Closet. D) A 3-4 inch hole through the door where latching hardware was missing in the Laundry door near the stairwell. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. 3.1-19(b)		**ensure a seal is identifiable and no penetrating holes are noted in their current state throughout the facility.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **Maintenance personnel will be educated to acknowledge doors with either penetrative holes and/or missing hardware, regardless of vicinity to residents, as items in need of repair. Audits will be performed throughout the facility once every other month for 3 months, and quarterly afterwards to check for penetrations in doors.** How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place; **Maintenance/designee will present 3 months of audit results to QAPI committee and progress will be assessed and adjusted as needed.**	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to			

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	terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.			
	Based on observation and interview, the facility failed to ensure all smoke barriers walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 16 residents and 8 staff. Findings include: Based on observation and interview during the facility tour with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 12:15 p.m. and 3:10 p.m., the following locations were missing	K 0372	**K372** What corrective actions will be accomplished for those residents found to have affected by the deficient practice; **Drywall will be patched and/or placed at the mentioned areas using the appropriate materials for life safety compliance.** How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken; **Facility will be checked for other smoke barrier penetrations and repair any findings.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **Maintenance/designee will be audit facility for areas that need drywall patching or placement. All noted areas of damage will be reported on a facility map. Audits will be performed once monthly × 3 months, quarterly × a year to keep compliance**. How will the corrective action be monitored to ensure the deficient	06/17/2022

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	completely sealed walls which would resist the passage of smoke; A. The 600 Hall TV room office had a approximately a 8 inch x 5 inch hole in the wall. B. Above the drop ceiling in the 300 hall, near the double door set, approximately 1/3rd of the smoke wall was missing near the HVAC metal trunk line. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. 3.1-19(b)		practice will not recur, i.e. what quality assurance programs will be put into place; **Maintenance/designee will present 3 months of audit results to QAPI committee and progress will be assessed and adjusted as needed.**	
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.			

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	19.3.7.6, 19.3.7.8, 19.3.7.9 1. Based on observation and interview, the facility failed to ensure all corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect up to 25 staff, visitors and residents. Findings include: Based on observation and interview during the facility tour with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 12:15 p.m. and 3:10 p.m., the double smoke door set on the 300 hall failed to close completely into the doorframe and resist the passage of smoke, leaving approximately a 3 inch gap. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. 2. Based on observation and interview, the facility failed to ensure 1 of over 10 sets of cross corridor doors had a fire protection rating of at least 20 minutes and would not resist the passage of smoke. This deficient practice could affect 3 staff. Findings include:	K 0374	**K374(1)** What corrective actions will be accomplished for those residents found to have affected by the deficient practice; **300-hall smoke doors will be repaired and aligned such that the doors create a proper seal.** How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken; **All other smoke doors will be inspected and tested to ensure a proper seal.** **K374(2)** What corrective actions will be accomplished for those residents found to have affected by the deficient practice; **Smoke doors on the 200-hall will be replaced with doors that have appropriate fire-rating labels and are rated for at least 20 minutes. All obstructions will be removed so door can open and close freely.** How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken; **All other smoke doors in facility will be inspected for the appropriate fire rating label.** What measures will be put into	06/17/2022

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	Based on observation and interview during the facility tour with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 12:15 p.m. and 3:10 p.m., the facility was unable to provide evidence that the double door set with the upper 1/3 of each door made with glass on the 200 hall provided at least a 20 minute fire protection rating. The door set lacked fire rating labels. The door set also did not close completely to resist the passage of smoke. A dangling exit sign above the door set prevented the doors from fully closing. The identification rating labels on the aforementioned door set could not be located and not other documentation was provided to demonstrate the doors rating. This finding was acknowledged by the Director of Plant Operations at the time of observation and again at the exit conference with the Director of Plant Operations and Administrator on 08/26/20 at 5:00 p.m. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. 3.1-19(b)		place or what systemic changes will be made to ensure that the deficient practice does not recur: **Maintenance/designee will check smoke doors throughout facility once quarterly to check for a proper seal between doors.** How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place; **Maintenance/designee will present 3 months of audit results to QAPI committee and progress will be assessed and adjusted as needed.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **Maintenance/designee will check smoke doors throughout facility once quarterly to check for a proper seal between doors.** How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place; **Maintenance/designee will present 3 months of audit results to QAPI committee and progress will be assessed and adjusted as needed.**	
K 0511 SS=F	NFPA 101 Utilities - Gas and Electric			

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Bldg. 01	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 that the emergency generator had a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 Edition, 5.1. LSC section 9.1.3.1 states emergency generators shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. A.5.1.1 states examples of probability of interruption could include the following: earthquake, flood damage, or a demonstrated utility unreliability. This deficient practice could affect all residents. Findings include:	K 0511	**K511** What corrective actions will be accomplished for those residents found to have affected by the deficient practice; **A letter from the natural gas supplier supporting that the provider is a reliable source will be added to the updated Life Safety binder.** How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken; **Access to a letter of reliability covers the entire facility and alleviates the practice from affecting all residents.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **Maintenance staff will be trained on putting together and keeping a life safety binder with readily viewable paper copies. Life Safety book will be audited once a week × 3 months, once a month × 6 months, and quarterly afterwards to keep compliance.**	06/17/2022

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	Based on records review and interview with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 9:45 a.m. and 12:15 p.m., the fuel source for the emergency generator was natural gas. Additionally, based on interview, the facility did not have a letter from their natural gas provider indicating the natural gas was from a reliable source. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. 3.1-19(b)		How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place; **Maintenance/designee will present 3 months of audit results to QAPI committee and progress will be assessed and adjusted as needed.**	
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2.			

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	18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review, observation and interview; the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 inches. (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants. Findings include:	K 0711	**K711** What corrective actions will be accomplished for those residents found to have affected by the deficient practice; **The written fire safety plan provided in the EPP binder will contain a section to include information regarding the relocation of wheeled carts from hallways to designated locations.** How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken; **By providing written direction, the whole facility should be covered under this change (1).** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **EPP binder will be audited once a week × 3 months, once a month × 6 months, and quarterly afterwards to maintain compliance.** How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place; **Maintenance/designee will present 3 months of audit**	06/17/2022

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	155831	A. BUILDING 01 B. WING	05/10/2022

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	Based on records review and interview with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 9:45 a.m. and 12:15 p.m., the written fire safety plan provided did not address the relocation of wheeled equipment during a fire or similar emergency. Based on observation during the facility tour, wheeled medical equipment was observed throughout the building. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. 3.1-19(b)		**results to QAPI committee and progress will be assessed and adjusted as needed.**	
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			

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	Based on record review and interview, the facility failed to conduct fire drills or documented orientation training on each shift for 2 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. QSO-20-31 1135 temporary waiver states in lieu of a physical fire drill, a documented orientation training program related to the current fire plan, which considers current facility conditions, is acceptable. The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area. This deficient practice affects all staff and patients. Findings include: Based on records review and interview with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 9:45 a.m. and 12:15 p.m., the following shifts were missing documentation of a completed fire drill or documented orientation training: a) All shifts in the First Quarter of 2022. b) All shifts in the Third Quarter of 2021 c) All shifts in the Fourth Quarter of 2021 d) 2 of 3 shifts in the Second Quarter of 2022 Based on interview at the time of record review, the Administrator in Training and the Director of Maintenance agreed there were 11out of 12 missing fire drills and staff has not been trained in the fire safety procedures for the 4 quarters.	K 0712	**K712** What corrective actions will be accomplished for those residents found to have affected by the deficient practice; **Fire drills or trainings will be documented and provided in an updated Life Safety binder. Drills or trainings will be performed at least quarterly.** How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken; **Fire drills or trainings shall be performed for all shifts.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **Maintenance staff will be trained on putting together and keeping a life safety binder with readily viewable paper copies. Life Safety book will be audited once a week × 3 months, once a month × 6 months, and quarterly afterwards to keep compliance.** How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place; **Maintenance/designee will present 3 months of audit results to QAPI committee and progress will be assessed and adjusted as needed.**	06/17/2022

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	This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. 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 apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas			

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	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 1 of 1 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect staff and 5 or more residents in the smoking area. Findings include: Based on observation and interview during the facility tour with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 12:15 p.m. and 3:10 p.m., in the (1) one designated smoking area there were over 30 cigarette butts disposed on the ground in and around the smoking area. Additionally, the smokers tower receptacle was in pieces and scattered no longer n the smoking area. The trashcans near the smoking area were full of cigarette butts. Based on interview at the time of observations, the Executive Director concluded there were over 30 cigarette butts on the ground in the aforementioned location. Also, (2) in the stairwell leading out of the basement to the outside, over 50 cigarette butts were observed in and around the entrance to the stairwell. The Assistant Maintenance Director stated that this area was not a designated smoking area, that the facility only had the one area designated for staff smoking and that residents at the facility do not smoke.	K 0741	**K741** What corrective actions will be accomplished for those residents found to have affected by the deficient practice; **Designated smoking area will be provided with a receptacle of appropriate build in the designated location.** How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken; **Education will be provided to staff about use of receptacle and smoking only in designated location. Existing butts will be cleaned from areas.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **Education will be provided to all staff regarding the use and importance of a designated smoking area.** How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place; **Maintenance/designee will present 3 months of audit**	06/17/2022

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	This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. 3.1-19(b)		**results to QAPI committee and progress will be assessed and adjusted as needed.**	
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation and interview, the facility failure to ensure 1 of 1 portable space heaters were not used in the facility. This deficient practice could affect up to 40 residents. Findings include: Based on observation and interview during the facility tour with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 12:15 p.m. and 3:10 p.m., a portable space heater was in use in 700 Hall Dining Area. The free standing electric fireplace was equipped with a thermostat and when tested produced heat. Based on interview at the time of the observations, the Assistant	K 0781	**K781** What corrective actions will be accomplished for those residents found to have affected by the deficient practice; **Identified electric fireplace will be disconnected and cut off from power and cut from being plugged in.** How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken; **All identified space heaters will be disconnected (with no**	06/17/2022

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	Maintenance Director agreed a space heater was being used in a resident care area and produced heat. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. 3.1-19(b)		**plug-in) or taken off the facility premises.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **Maintenance will check facility for space heaters quarterly to maintain compliance.** How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place; **Maintenance/designee will present 3 months of audit results to QAPI committee and progress will be assessed and adjusted as needed.**	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and			

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	automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1 Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 9 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on records review and interview with the	K 0918	**K918** What corrective actions will be accomplished for those residents found to have affected by the deficient practice; **Monthly generator load tests and emergency battery-powered lamps will be completed and documented monthly in an updated Life Safety binder for review.** How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken; **Monthly tests will utilize the generator which functions for the whole facility.** What measures will be put into place or what systemic changes will be made to ensure that the	06/17/2022

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	Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 9:45 a.m. and 12:15 p.m., only November and December of 2021 and January of 2022 documentation was provided to show the generator set in service was exercised at least once monthly, for a minimum of 30 minutes. Records for the remaining months were missing. The Maintenance Director attempted to locate the records in the TELS program, but not documentation or visual confirmation was provided during the survey. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. 2. Based on observation and interview, the facility failed to ensure 1 of 1 emergency task generator battery backup lights were maintained. NFPA 110, 2010 Edition at section 7.3.1 requires the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery		deficient practice does not recur: **Maintenance staff will be trained on putting together and keeping a life safety binder with readily viewable paper copies. Life Safety book will be audited once a week × 3 months, once a month × 6 months, and quarterly afterwards to keep compliance.** How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place; **Maintenance/designee will present 3 months of audit results to QAPI committee and progress will be assessed and adjusted as needed**	

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	powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on records review and interview with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 9:45 a.m. and 12:15 p.m., no documentation was available for review to show the emergency battery powered light at the generator was tested monthly for a minimum of 30 seconds or annually for 90 minutes. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. 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			

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	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 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			
	1. Based on observation and interview, the facility failed to ensure all rooms did not used multi-plug adaptors as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, 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 affects 3 staff. Findings include: Based on observation and interview during the facility tour with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 12:15 p.m. and 3:10 p.m., the maintenance office in the	K 0920	**K920** What corrective actions will be accomplished for those residents found to have affected by the deficient practice; **Multi-plug adapters, and power strips will be removed, corrected, and substituted for a viable, compliant, alternative.** How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken; **The facility will be toured in its entirety to check for these occurrences.** What measures will be put into place or what systemic changes will be made to ensure that the	06/17/2022

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	basement contained a multi-plug adaptor powering computers and other electrical equipment behind the desk.. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. 2. Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 3 residents and 3 staff. Findings include: Based on observation and interview during the facility tour with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 12:15 p.m. and 3:10 p.m., (1) in the Restorative Office a power strip was being used to power door style refrigerator (high power draw equipment). And (2) in the Business office two green extension cords were being used to power a microwave and door style refrigerator (high power draw equipment).		deficient practice does not recur: **Maintenance will be assigned a rounding checklist remove and correct any occurrences of these events. A round will be performed immediately with notations on alternative options for utilizing equipment and once a quarter from there on out. Staff will be educated on the appropriate application of these devices in NF's.** How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place; **Maintenance/designee will present 3 months of audit results to QAPI committee and progress will be assessed and adjusted as needed.**	

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BRIARCLIFF HEALTH & REHABILITATION CENTER	5024 WESTERN AVENUE SOUTH BEND, IN 46619

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. 3.1-19(b)			
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 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 up to 10 residents.	K 0927	**K927** What corrective actions will be accomplished for those residents found to have affected by the deficient practice; **A light fixture will be provided to the O2 transfilling station room, an "in-use" slider will be mounted and provided near the station, and the room will be**	06/17/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	05/10/2022

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	Findings include: Based on records review and interview with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 9:45 a.m. and 12:15 p.m., no documentation was available for review to indicate staff that trans-fill liquid oxygen were properly trained. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. 2. Based on observation and interview, the facility failed to ensure 1 of 1 oxygen transfilling rooms had lighting. NFPA 99, Health Care Facilities Code, 2012 edition, Section 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated, is sprinklered, and have ceramic or concrete flooring. This deficient practice could affect 30. Findings include: Based on observation and interview during the facility tour with the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 12:15 p.m. and 3:10 p.m., the oxygen storage/transfilling room did not have any lighting source, making it		**adjusted such that there is ample space to stand in the room.** How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken; **Proper O2 transfilling training will be provided to current staff and will be supplied to new staff during orientation. Documentation of training will be included in orientation process.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **DON/designee will educate all relevant nursing personnel on proper transfilling procedures. Maintenance/designee will interview at least 3 staff members per week until compliance has been met for at least one month.** How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place; **Maintenance/designee will present 3 months of audit results to QAPI committee and progress will be assessed and adjusted as needed.**	

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	impossible to see when inside the room and the door in the closed position. The available QMA, when asked to demonstrate how oxygen was transferred, stood with the door propped open with her foot to simulate the process. The QMA when asked if this is how most people in the facility preform this procedure stated, yes. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. 3.1-19(b)			