| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155384 | A. BUILDING -- B. WING | 10/17/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER | 402 19TH STREET TELL CITY, IN 47586 |

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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 10/17/22<br><br>Facility Number: 000411<br>Provider Number: 155384<br>AIM Number: 100275100<br><br>At this Emergency Preparedness survey, Brickyard Healthcare-Lincoln Hills Care Center was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73<br><br>The facility has a capacity of 86 certified beds and had a census of 64 at the time of this visit.<br><br>Quality Review completed on 10/21/22 | E 0000 | Preparation and submission of this Plan of Correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the facility has prepared and submits this Plan of Correction solely as a requirement under State and Federal Law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and Title 19 programs, and to provide the best care possible to our residents.<br><br>We would like to respectfully request a desk review. | |
| E 0041<br>SS=C<br>Bldg. -- | 482.15(e), 483.73(e), 485.625(e)<br>Hospital CAH and LTC Emergency Power<br>§482.15(e) Condition for Participation:<br>(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.<br><br>§483.73(e), §485.625(e)<br>(e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Julie Pennington | Executive Director | 10/28/2022 |

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| | systems based on the emergency plan set forth in paragraph (a) of this section.<br><br>§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.<br><br>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.<br><br>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.<br><br>*[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 | | | |

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| | 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.<br>(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.<br>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.<br>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.<br>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.<br>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.<br>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.<br>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.<br>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.<br>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.<br>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.<br>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.<br>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013. | | | |

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| | (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..<br>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).<br><br>Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during the past 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. 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, staff and visitors.<br><br>Findings include:<br><br>Based on record review on 10/17/22 between 10:00 a.m. and 1:45 p.m. with the Maintenance Director present, there was no documentation on the emergency generator monthly test form for percentage of load during the monthly load tests during the past 12 months. The information provided always said "NA" for "% of Nameplate KW". Based on interview at the time of record review, the Maintenance Director agreed there was no documentation provided on the monthly generator load test form for percentage of load | E 0041 | What corrective action will be taken for those residents found to have been affected by the deficient practice. Generator is being tested monthly under load and the percent of Nameplate KW is being recorded in the field where "NA" was previously being entered.<br><br>How will other residents with the potential to be affected by the same deficient practice be identified. All residents have the potential to be affected by this practice. Generator is being tested monthly under load and the percent of Nameplate KW is being recorded in the field where "NA" was previously being entered.<br><br>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Monthly testing is being recorded in Building Engines.<br><br>How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Results of the Building Engines monthly test will be reviewed monthly in the Quality Assurance meeting for six months or until no further corrective action | 11/17/2022 |

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| | during the past 12 months.<br><br>This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. | | is needed. | |
| K 0000<br><br>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).<br><br>Survey Date: 10/17/22<br><br>Facility Number: 000411<br>Provider Number: 155384<br>AIM Number: 100275100<br><br>At this Life Safety Code survey, Brickyard Healthcare-Lincoln Hills Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>This one story facility with a lower level was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 86 and had a census of 64 at the time of this survey.<br><br>All areas where the residents have customary | K 0000 | Preparation and submission of this Plan of Correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the facility has prepared and submits this Plan of Correction solely as a requirement under State and Federal Law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and Title 19 programs, and to provide the best care possible to our residents.<br><br>We would like to respectfully request a desk review. | |

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| | access were sprinklered, except resident room closets, and all areas providing facility services were sprinklered except a metal shed containing facility storage.<br><br>Quality Review completed on 10/21/22 | | | |
| K 0100 SS=E Bldg. 01 | NFPA 101<br>General Requirements - Other<br>General Requirements - Other<br>List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.<br>Based on observation and interview, the facility failed to ensure 1 of 1 laundry area dryer room enclosure was free of lint and dirt. NFPA 101 at 19.1.1.3.1 states all health care facilities shall be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect mostly laundry staff, plus residents in the same smoke compartment.<br><br>Findings include:<br><br>Based on observations on 10/17/22 between 1:45 p.m. and 4:30 p.m. during a tour of the facility with the Maintenance Director, the floor and equipment in the back of the dryer enclosure within the laundry area was substantially covered with dryer lint. Based on interview at the time of observation, the Maintenance Director agreed there was a substantial amount of dryer lint on the floor and equipment within the enclosure behind the dryers, and further said they would increase | K 0100 | What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Equipment in the laundry room was cleaned to eliminate lint build up.<br><br>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this practice.<br><br>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? A monthly general lint inspection checklist was added to Building Engines to ensure lint is removed | 11/17/2022 |

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| | the cleaning schedule.<br><br>This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.<br><br>3.1-19(b) | | from all equipment, walls and sprinklers. Audits will be conducted 5x per week for one month, 4x per week for one month, 3x per week for one month, 2x per week for one month and 1x per week for two months or until no further corrections are needed,<br><br>How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Results of the audits and general lint inspection from Building Engines will be reviewed monthly for six months in the Quality Assurance Meeting or until no further corrections are needed, | |
| K 0211<br>SS=E<br>Bldg. 01 | NFPA 101<br>Means of Egress - General<br>Means of Egress - General<br>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.<br>18.2.1, 19.2.1, 7.1.10.1<br>Based on observation and interview, the facility failed to ensure 2 of 11 corridor means of egress were continuously maintained free of obstructions. This deficient practice could affect at least 20 residents, as well as staff and visitors.<br><br>Findings include: | K 0211 | What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The lift in front of the door was removed from in front of the exit door of Station 4. The recliner was removed from in | 11/17/2022 |

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| | Based on observations on 10/17/22 between 1:45 p.m. and 4:30 p.m. during a tour of the facility with the Maintenance Director, the following was noted:<br>a. There was a lift placed in front of the Station 4 north exit door.<br>b. There was a recliner placed in front of the Station 2 north exit door.<br>Based on interview at the time of each observation, the Maintenance Director acknowledged the items stored in front of the two exit doors.<br><br>This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.<br><br>3.1-19(b) | | front of the exit door of Station 2.<br><br>How will other residents having th potential to be affected by the same deficient practice be identified and what corrective action will be taken. All residents in the area have the potential to be affected by this practice. The lift in front of the door was removed from in front of the exit door on Station 4 and the recliner was removed from in front of the exit door on Station 2.<br><br>What measures will be put into place and what system changes will be made to ensure that the deficient practice does not recur. A daily interior rounds task was added to Building Engines to inspect each hallway and exit to ensure no obstruction to exit or egress is present. Staff will be educated to keep exits clear of obstruction.<br><br>How will the corrective action be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place. Results of the Building Engines inspection will be reviewed monthly in the Quality Assurance Process Improvement meeting monthly for 6 months or until no further corrective action is needed. | |

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| K 0271 SS=E Bldg. 01 | NFPA 101<br>Discharge from Exits<br>Discharge from Exits<br>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.<br>18.2.7, 19.2.7<br>Based on observation and interview, the facility failed to maintain the walking surface for 1 of over 10 exit discharge areas. This deficient practice could affect mostly staff and any residents while in the Beauty Shop.<br><br>Findings include:<br><br>Based on observations on 10/17/22 between 1:45 p.m. and 4:30 p.m. during a tour of the facility with the Maintenance Director, the north exit from the lower level west hall had a two inch level change between the concrete slab and the connecting sidewalk to the public way. The level change in the concrete slab and connecting sidewalk to the public way could be a tripping hazard while exiting from this area in the event of an emergency. Based on interview at the time of each observation, the Maintenance Director said he was not aware of the level change in the concrete slab and connecting sidewalk.<br><br>This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.<br><br>3.1-19(b) | K 0271 | What corrective action will be accomplished for those residents found to have been affected by this deficient practice. The elevation change will be repaired with concrete to prevent the tripping hazard.<br><br>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken. All residents exiting through this area have the potential to be affected by this practice. The elevation change will be repaired to prevent the tripping hazard.<br><br>What measures will be put into place and what system changes will be made to ensure that the deficient practice does not recur. A step was added to daily exterior rounds in Building Engines to inspect walkways for cracks and elevation changes that could be a trip hazard and repaired | 11/17/2022 |

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| | | | immediately.<br><br>How will be corrective action be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place. Results of the Building Engines inspections will be reported monthly in the Quality Assurance meeting for six months or until no further corrective action is needed. | |
| K 0291<br>SS=C<br>Bldg. 01 | NFPA 101<br>Emergency Lighting<br>Emergency Lighting<br>Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.<br>18.2.9.1, 19.2.9.1<br>Based on record review, observation, and interview; the facility failed to ensure there was complete documentation for the testing of all battery backup lights that were tested monthly for 30 seconds during the past 12 months, and annually for 90 minutes during the past 12 months to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. 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 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 | K 0291 | What corrective action will be accomplished for those residents found to have been affected by this deficient practice. All emergency battery operated lighting has been removed inside the facility as it is fully powered by the generator.<br><br>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken. All residents have the potential to be affected by this practice. All emergency battery operated lighting has been removed inside the facility as it is fully powered by the generator.<br><br>What measures will be put into | 11/17/2022 |

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| | residents, as well as staff and visitors in the facility.<br><br>Findings include:<br><br>Based on record review on 10/17/22 between 10:00 a.m. and 1:45 p.m. with the Maintenance Director present, the facility did have a preventative maintenance (PM) report that battery powered emergency lights were tested monthly for 30 seconds and annually for 90 minutes, however, the monthly and annual PM's was not an itemized list of where the battery powered emergency lights were located and did not indicate the test results (pass/fail). Based on an interview at the time of record review, the Maintenance Director agreed the PM form for the battery powered emergency lights was not an itemized list and did not show the test results.<br><br>This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.<br><br>3.1-19(b) | | place and what systemic changes will be made to ensure that the deficient practice does not recur. Audits will be done 5x per week for one month, 4x per week for one month, 3x per week for one month, 2x per week for one month and 1x per week for two months to ensure the emergency battery lighting is not used.<br><br>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program put into place. The audits will be reviewed monthly in the Quality Assurance meeting for six months or until no further corrective action is needed. | |
| K 0293 SS=E Bldg. 01 | NFPA 101<br>Exit Signage<br>Exit Signage<br>2012 EXISTING<br>Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.<br>19.2.10.1<br>(Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)<br>Based on observation and interview, the facility failed to ensure 1 of over 30 exit signs were | K 0293 | What corrective action will be accomplished for those residents | 11/17/2022 |

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| | continuously illuminated. This deficient practice could affect at least 10 residents, as well as staff and visitors.<br><br>Findings include:<br><br>Based on observations on 10/17/22 between 1:45 p.m. and 4:30 p.m. during a tour of the facility with the Maintenance Director, the exit sign at the west end of the Business Office hall was not illuminated. Based on interview at the time of observation, the Maintenance Director said he was aware that the exit sign was not illuminated and has a new exit sign on order to replace it with.<br><br>This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.<br><br>3.1.19(b) | | found to have been affected by the deficient practice. Exit signage was repaired at the end of the business office hall. All exit signs were checked for proper illumination.<br><br>How will other residents be having the potential to be affected by the same deficient practice be identified and what corrective action will be taken. All residents near the stated exit have the potential to be affected by this practice. Exit storage signage was repaired at the west end of the business office hall. All exit signs were checked for proper illumination.<br><br>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. A step was added to daily interior rounds in Building Engines to inspect all exit signs and their lighting to ensure proper operation.'<br>'<br>How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Results of the Building Engines inspections will be reviewed in the monthly Quality Assurance meeting for six months or until no further corrective action is needed. | |

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| K 0300 SS=C Bldg. 01 | NFPA 101<br>Protection - Other<br>Protection - Other<br>List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.<br>Based on record review and interview, the facility failed to ensure documentation for the preventative maintenance of battery operated smoke alarms in all resident rooms was complete. NFPA 72 14.2.1.1.1 states to ensure operations integrity, the system shall have an inspection, testing, and maintenance program. NFPA 72 29.10 states fire-warning equipment shall be maintained and tested in accordance with manufacturer's published instructions and per the requirements of Chapter 14. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review on 10/17/22 between 10:00 a.m. and 1:45 p.m. with the Maintenance Director present, there was documentation available that battery operated smoke alarms in all resident rooms were tested monthly, however, the documentation provided, titled "Battery Operated Smoke Detectors Maintenance Log" was just a blanketed statement that all resident room smoke alarms were tested on each of the three units. There was no itemized list of which room smoke alarms were tested and the results of each test. Based on interview at the time of record review, the Maintenance Director confirmed there was no itemized list of each resident room smoke alarm. | K 0300 | What corrective action will be accomplished for those residents found to have been affected by the deficient practice. All battery-operated smoke detectors were tested.<br><br>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken. All residents have the potential to be affected by this practice. All battery-operated smoke detectors were tested.<br><br>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Audits will be conducted to ensure the battery-operated smoke detectors are tested and will be completed 5x weekly for one month, 4x weekly for one month, 3x weekly for one month, 2x weekly for one month an 1x weekly for two months or until no further corrective action is | 11/17/2022 |

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| | This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.<br><br>3.1-19(b) | | needed.<br><br>How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Audits will be reviewed monthly in the Quality Assurance meeting for six months or until no further corrective action is needed. | |
| K 0321<br>SS=E<br>Bldg. 01 | NFPA 101<br>Hazardous Areas - Enclosure<br>Hazardous Areas - Enclosure<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops | | | |

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| | d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms (exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K322)<br>Based on observation and interview, the facility failed to ensure the corridor doors to 4 of over 20 hazardous area doors, such as a dry food storage room door, a Medical Waste room, and shower rooms containing soiled linen and trash carts, were provided with properly working self closing devices, and were not impeded from closing. This deficient practice could affect at least 10 residents, as well as staff, and visitors.<br><br>Findings include:<br><br>Based on observations on 10/17/22 between 1:45 p.m. and 4:30 p.m. during a tour of the facility with the Maintenance Director, the following was noted:<br>a. The Medical Waste storage room was over 50 square feet in size and full of medical waste, cardboard boxes and plastic. The door was provided with a self closing device, however, the door did not close completely and latch when tested several times.<br>b. The Dietary Food Storage Room was over 50 square feet in size and full of cardboard boxes, paper, and plastic items. The door was held wide open with a wood door wedge. There were no staff in or near this room at the time of observation.<br>c. Both shower rooms on Station 2 were over 50 square feet in size and both contained trash and soiled linen carts totaling more than 32 gallons. The corridor doors to both bathrooms were held | K 0321 | What corrective action will be accomplished for those residents found to have been affected by this deficient practice? The medical waste storage room was repaired to self close and latch. The dietary food storage room wedge was removed from the door. The station 2 shower room doors which had door obstructing shower room chairs were removed and were repaired to self-close and latch.<br><br>How will other residents having the potential to be affected by the same deficient practice be identified. All residents in the stated areas have the potential to be affected by this practice.<br><br>What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur. A step was added to the daily interior round in building engines to check all hazardous storage and all storage over 50 square feet to ensure the door will self close and latch. Staff will be educated on not blocking doors with | 11/17/2022 |

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| | open with shower chairs. There were no staff in the area at the time of observation.<br>Based on interview at the time of each observation, the Maintenance Director agreed the doors to these hazardous area rooms did not self close completely and latch automatically when tested, and were being held open with objects.<br><br>This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.<br><br>3.1-19(b) | | objects.<br><br>How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Results of the daily interior rounds inspection will be reviewed in QAPI monthly for six months or until no further corrective action is needed, | |
| K 0353<br>SS=E<br>Bldg. 01 | NFPA 101<br>Sprinkler System - Maintenance and Testing<br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.<br>Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>1. Based on observation and interview, the facility failed to ensure the ceiling in 1 of 4 sprinklered smoke compartments in the lower level was maintained to allow sprinkler heads to function to their full capability. This deficient | K 0353 | What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Ceiling tile missing in the wheelchair storage | 11/17/2022 |

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| | practice could affect mostly staff and one resident while in the Beauty Shop (same smoke compartment).<br><br>Findings include:<br><br>Based on observations on 10/17/22 between 1:45 p.m. and 4:30 p.m. during a tour of the facility with the Maintenance Director, the following was noted:<br>a. There was one missing ceiling tile in the lower level wheel chair storage room.<br>b. There was one missing ceiling tile in the lower level Activity Storage Room.<br>c. There were two missing ceiling tiles in the lower level Key Room.<br>Based on interview at the time of each observation, the Maintenance Director acknowledged the missing ceiling tiles in the various rooms in the lower level.<br><br>This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.<br><br>3.1-19(b)<br><br>2. Based on observation and interview, the facility failed to ensure sprinkler heads in 2 of 11 smoke compartments covered with lint/dirt were properly cleaned. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) | | room was replaced. The ceiling tile in the activity storage room was replaced. The two missing ceiling tiles in the key room were replaced. Six laundry sprinkler heads were cleaned. Unit 4 shower room sprinkler head next to the air supply vent was cleaned. FDC signage was placed at the front of the building pointing toward the FDC and FDC signage was placed above the fire department connection.<br><br>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken. All residents have the potential to be affected by this practice.<br>Ceiling tile missing in the wheelchair storage room was replaced. The ceiling tile in the activity storage room was replaced. The two missing ceiling tiles in the key room were replaced. Six laundry sprinkler heads were cleaned. Unit 4 shower room sprinkler head next to the air supply vent was cleaned. FDC signage was placed at the front of the building pointing toward the FDC and FDC signage was placed above the fire department connection.<br><br>What measures will be put into place and what systemic changes will be made to ensure that the | |

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| | Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect residents in Physical Therapy area, as well as laundry staff and others within the smoke compartments.<br><br>Findings include:<br><br>Based on observations on 10/17/22 between 1:45 p.m. and 4:30 p.m. during a tour of the facility with the Maintenance Director, the following was noted:<br>a. There were six sprinkler heads in the Laundry area covered with lint/dust.<br>b. There was one sprinkler head in the Unit 4 shower room next to the air supply vent covered with dust/dirt.<br>Based on interview at the time of each observation, the Maintenance Director agreed the previously mentioned sprinkler heads were covered with lint/dust/dirt and should be properly cleaned.<br><br>This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.<br><br>3.1-19(b)<br><br>3. Based on observation and interview, the facility failed to ensure 1 of 1 fire department connections were in accordance with NFPA 25, 2011 Edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 13.7.1 requires fire department connections to be inspected quarterly to verify the following:<br>(1) The fire department connections are visible and accessible.<br>(2) Couplings or swivels are not damaged and | | deficient practice does not recur. Audits will be conducted 5x weekly for one month, 4x weekly for one month, 3x weekly for one month, 2x weekly for one month and 1x weekly for two months for sprinkler inspections, checks for gaps in ceiling tiles, or missing ceiling tiles, dirty sprinkler heads and FDC signage.<br><br>How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Audits will be reviewed monthly in the Quality Assurance meeting or until no further action is needed. | |

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| | rotate smoothly.<br>(3) Plugs or caps are in place and undamaged.<br>(4) Gaskets are in place and in good condition.<br>(5) Identification signs are in place.<br>(6) The check valve is not leaking.<br>(7) The automatic drain valve is in place and operating properly.<br>(8) The fire department connection clapper(s) is in place and operating properly.<br>This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on observations on 10/17/22 between 1:45 p.m. and 4:30 p.m. during a tour of the facility with the Maintenance Director, the facility's fire department connections (FDC) was located on the side of the facility not seen from the front of the building. There was no FDC signage provided around the fire department connection or at the front of the building for the responding fire department to lead them to the FDC for easy identification. Based on interview at the time of observation, this was acknowledged by the Maintenance Director who agreed there should be FDC signage at the FDC and the front of the facility.<br><br>This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.<br><br>3.1-19(b) | | | |
| K 0511<br>SS=B<br>Bldg. 01 | NFPA 101<br>Utilities - Gas and Electric<br>Utilities - Gas and Electric<br>Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment | | | |

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| | complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.<br>18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2<br>Based on observation and interview, the facility failed to ensure 2 of over 10 electrical panels observed in the facility corridors were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B).<br>(A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B).<br>(B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect all residents, staff and visitors while in the lower level west hall.<br><br>Findings include:<br><br>Based on an observations on 10/17/22 between 1:45 p.m. and 4:30 p.m. during a tour of the facility with the Maintenance Director, two electrical panels observed in the lower level west corridor were unlocked when tested. The side by side panels included breakers to a variety of items in the facility. Based on interview at the time of observation, the Maintenance Director agreed all electrical panels in the facility corridors need to be locked.<br><br>This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. | K 0511 | What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Two electrical panels in the lower level were locked to prevent access by unauthorized personnel.<br><br>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken. All residents in the area have the potential to be affected by this practice.<br><br>What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur. A step was added to the daily interior rounds to check all electrical panels to ensure they are locked and inaccessible to unauthorized personnel.<br><br>How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Results of the daily interior rounds inspecting the panel locks will be reported in the monthly QAPI meeting for six months or until no further corrective action is needed. | 11/17/2022 |

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| | 3.1-19(b) | | | |
| K 0541 SS=E Bldg. 01 | NFPA 101<br>Rubbish Chutes, Incinerators, and Laundry Chu<br>Rubbish Chutes, Incinerators, and Laundry Chutes<br>2012 EXISTING<br>(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5.<br>(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7.<br>(3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.)<br>(4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use.<br>19.5.4, 9.5, 8.4, NFPA 82<br>Based on observation and interview, the facility failed to maintain 1 of 1 laundry chute door to be fully self-closing and positive latching. LSC 9.5.2 requires trash chutes shall be installed and maintained per NFPA 82, 2009 Edition. NFPA 82 5.2.3.3.1.1 requires all chute loading doors into a trash chute shall be provided with a self-closing, | K 0541 | What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Laundry chute door was repaired to self-close and latch. | 11/17/2022 |

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| | positive latching frame and gasketed door assembly. This deficient practice could affect over 20 residents, as well as staff and visitors.<br><br>Findings include:<br><br>Based on observation on 10/17/22 between 1:45 p.m. and 4:30 p.m. during a tour of the facility with the Maintenance Director, the main level laundry chute door would not close completely and latch into its frame when tested several times. Based on interview at the time of observation, the Maintenance Director agreed the laundry chute door did not operate as designed.<br><br>This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.<br><br>3.1-19(b) | | How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken. All residents have the potential to be affected by this practice. Laundry chute door was repaired to self-close and latch.<br><br>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. A step was added to the daily interior rounds in Building Engines to check for proper closing and latching of the laundry chute door.<br><br>How will the corrective action be monitored to ensure the deficient practice will not recur, i.e/, what quality assurance program will be put into place. Results of the daily interior rounds check of the laundry chute door will be reported to QAPI monthly for six months or until no further corrective action is needed. | |
| K 0712<br>SS=F<br>Bldg. 01 | NFPA 101<br>Fire Drills<br>Fire Drills<br>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected | | | |

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| | 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.<br>19.7.1.4 through 19.7.1.7<br>1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 3 of 3 shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility.<br><br>Findings include:<br><br>Based on review of the facility's fire drill reports on 10/17/22 between 10:00 a.m. and 1:45 p.m. with the Maintenance Director present, the facility lacked fire drill documentation for the following shifts and quarters during the past 12 month period:<br>a. First shift (day) of the fourth quarter (October, November, and December) of 2021<br>b. Second shift (evening), and third shift (night) of the fourth quarter (October, November, and December) of 2021, and first quarter (January, February, and March), second quarter (April, May, and June), and third quarter (July, August, and September) of 2022<br>Based on interview at the time of record review, the Maintenance Director confirmed the lack of a fire drill reports for the previously mentioned shifts and quarters.<br><br>This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. | K 0712 | What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Fire drills are being conducted once per shift per quarter and now include the name of the technician verifying the signal.<br><br>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken. All residents have the potential to be affected by this practice.<br><br>What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur. Fire drill completion will be tracked in the fire alarm #1 monthly fire drills section of building engines to ensure the paper fire drill was completed including evidence that the monitoring company received the fire drill.<br><br>How will the corrective action be monitored to ensure the deficient | 11/17/2022 |

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| | 3.1-19(b)<br><br>2. Based on record review and interview, the facility failed to ensure 5 of 5 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents.<br><br>Findings include:<br><br>Based on review of the facility's fire drill reports on 10/17/22 between 10:00 a.m. and 1:45 p.m. with the Maintenance Director present, all five fire drill reports performed during the past 12 month period did not include documentation for the transmission of the alarm to the monitoring company. Based on interview at the time of record review, the Maintenance Director acknowledged there was no information on all five fire drill reports to verify that transmission of the alarm was received by the monitoring company.<br><br>This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.<br><br>3-1.19(b) | | practic will not recur, i.e., what quality assurance program will be put into place. Results of the Building Engines fire alarm system #1 fire drill inspection will be reported monthly in the Quality Assurance meeting for six months or until no further corrective action is needed. | |
| K 0741<br>SS=E<br>Bldg. 01 | NFPA 101<br>Smoking Regulations<br>Smoking Regulations<br>Smoking regulations shall be adopted and shall include not less than the following provisions:<br>(1) Smoking shall be prohibited in any room, | | | |

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| | 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.<br>(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.<br>(3) Smoking by patients classified as not responsible shall be prohibited.<br>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.<br>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.<br>(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.<br>18.7.4, 19.7.4 | | | |
| | Based on observation and interview, the facility failed to ensure cigarette butts were properly disposed of at 2 of 2 area where cigarettes were smoked by residents and staff. This deficient practice could affect at least 3 residents and staff.<br><br>Findings include:<br><br>Based on observations on 10/17/22 between 1:45 p.m. and 4:30 p.m. during a tour of the facility with the Maintenance Director, the following was noted:<br>a. The smoking area outside the lower level west hall had an open metal bucket 1/3 full of cigarette butts with paper trash and dry leaves. | K 0741 | What corrective action will be accomplished for those residents found to have been affected by this deficient practice. The smoking areas outside near the lower level west hall and near the outside east hall were equipped with an ash tray of noncombustible material and safe design. The trash can was moved from the area of east hall and cigarette butts, paper trash and leaves were removed. Staff were inserviced on proper disposal of smoking materials and to clean the area | 11/17/2022 |

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| | b. The smoking area outside the lower level east hall had at least 10 cigarette butts in the trash can with paper trash.<br>Based on interview at the time of each observation, the Maintenance Director acknowledged the paper trash and dried leaves mixed with the cigarette butts.<br><br>This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.<br><br>3.1-19(b) | | they are utilizing as well as only using dedicated smoke areas.<br><br>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken. All residents in the area have the potential to be affected by this practice. The smoking areas outside near the lower level west hall and near the outside east hall were equipped with an ash tray of noncombustible material and safe design. The trash can was moved from the area of east hall and cigarette butts, paper trash and leaves were removed. Staff were inserviced on proper disposal of smoking materials and to clean the area they are utilizing as well as only using dedicated smoke areas.<br><br>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Checking for proper smoking receptacles near the smoking areas has been added to the daily exterior rounds portion of Building Engines.<br><br>How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place. The results of the | |

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| | | | daily exterior rounds inspection will be reported in the monthly Quality Assurance meeting for six months or until no further corrective action is needed. | |
| K 0761 SS=C Bldg. 01 | Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 1 of 1 oxygen room fire door assembly and 2 of 2 stairway fire door assemblies was completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly.<br><br>NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified:<br>(1) No open holes or breaks exist in surfaces of either the door or frame. | K 0761 | What corrective action will be accomplished for those residents found to have been affected by the deficient practice. A fire door inspection will be conducted to add the missing O2 transfilling room and both upper and lower stairwell doors.<br><br>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken. All residents near the O2 room and stairwell doors have the potential to be affected by this practice. A fire door inspection was conducted to add the missing O2 transfilling room and both upper and lower stairwell doors.<br><br>What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur. An annual fire door inspection was added to the building engines which includes the O2 room door and both upper and lower stairwell doors. | 11/17/2022 |

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| | (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.<br>(3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.<br>(4) No parts are missing or broken.<br>(5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.<br>(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.<br>(7) If a coordinator is installed, the inactive leaf closes before the active leaf.<br>(8) Latching hardware operates and secures the door when it is in the closed position.<br>(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.<br>(10) No field modifications to the door assembly have been performed that void the label.<br>(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity.<br>This deficient practice could affect all residents, as well as staff, and visitors.<br><br>Findings include:<br><br>Based on record review on 10/17/22 between 10:00 a.m. and 1:45 p.m. with the Maintenance Director present, the facility was unable to provide documentation for an annual inspection of the oxygen transfilling room fire door assembly and the two stairway fire door assemblies. Based on interview at the time of record review, the Maintenance Director said there was no documentation of an annual inspection of the oxygen transfilling room fire door assembly or the two stairway fire door assemblies. Based on | | How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The results of the annual fire door inspection will be reviewed in the monthly Quality Assurance meeting for six months or until no further corrective action is needed. | |

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| | observations during a tour of the facility with the Maintenance Director between 1:454 p.m. and 4:30 p.m., it was confirmed there was one oxygen transfilling room fire door assembly and two stairway fire door assemblies noted in the facility.<br><br>This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.<br><br>3.1-19(b) | | | |
| K 0918<br>SS=C<br>Bldg. 01 | NFPA 101<br>Electrical Systems - Essential Electric Syste<br>Electrical Systems - Essential Electric System Maintenance and Testing<br>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.<br>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 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 | | | |

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| | 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.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during the past 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. 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, staff and visitors.<br><br>Findings include:<br><br>Based on record review on 10/17/22 between 10:00 a.m. and 1:45 p.m. with the Maintenance Director present, there was no documentation on the emergency generator monthly test form for percentage of load during the monthly load tests during the past 12 months. The information provided always said "NA" for "% of Nameplate KW". Based on interview at the time of record review, the Maintenance Director agreed there was no documentation provided on the monthly generator load test form for percentage of load during the past 12 months. | K 0918 | What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. The percent of nameplate KW value is now being recorded in the monthly full load generator test.<br><br>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken. All residents have the potential to be affected by this deficient practice. The percent of nameplate KW value is now being recorded in the monthly full load generator test.<br><br>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. A step has been added and is being utilized to record the percent of nameplate KW value in the monthly full load generator test in Building Engines.<br><br>How will the corrective action be | 11/17/2022 |

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| | This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.<br><br>3.1-19(b) | | monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Results of the monthly generator test with recorded percent of the KW value in Building Engines will be reviewed monthly in the Quality Assurance meeting for six months or until no further action is required. | |
| K 0920 SS=D Bldg. 01 | NFPA 101<br>Electrical Equipment - Power Cords and Extens<br>Electrical Equipment - Power Cords and Extension Cords<br>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips 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 | | | |

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| | Based on observation and interview, the facility failed to ensure a power strip was not used as a substitute for fixed wiring in 1 of 1 staff Dietary Office. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff only.<br><br>Findings include:<br><br>Based on observations on 10/17/22 between 1:45 p.m. and 4:30 p.m. during a tour of the facility with the Maintenance Director, there was a microwave and small refrigerator plugged into a power strip in the staff Dietary Office. Based on interview at the time of observation, the Maintenance Director acknowledged the use of the power strip in the staff Dietary Office.<br><br>This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.<br><br>3.1-19(b) | K 0920 | What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The microwave and refrigerator were unplugged from the power strip and directly plugged into the wall.<br><br>How will other residents having the potential to be affected by this same deficient practice be identified and what corrective action will be taken. All residents in the area have the potential to be affected by this practice. The microwave and refrigerator were unplugged from the power strip and directly plugged into the wall.<br><br>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. A quarterly inspection was created in building engines to check the facility for power cords and proper use of power strips. Random audits will be conducted 5x weekly for one month, 4x weekly for one month, 3x weekly for one month, 2x weekly for one month and 1x weekly for two months. Staff will be educated on the proper use of power strips.<br><br>How will the corrective action be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place. Results of the | 11/17/2022 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155384 | A. BUILDING 01<br>B. WING | 10/17/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER | 402 19TH STREET<br>TELL CITY, IN 47586 |

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| | | | audits will be reviewed monthly in the Quality Assurance meeting for six months or until no further corrective action is needed. | |
| K 0923 SS=E Bldg. 01 | NFPA 101<br>Gas Equipment - Cylinder and Container Storag<br>Gas Equipment - Cylinder and Container Storage<br>Greater than or equal to 3,000 cubic feet<br>Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.<br>>300 but <3,000 cubic feet<br>Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.<br>Less than or equal to 300 cubic feet<br>In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure.<br>Cylinders must be handled with precautions as specified in 11.6.2.<br>A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."<br>Storage is planned so cylinders are used in order of which they are received from the | | | |

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| | supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.<br>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) | | | |
| | Based on observation and interview, the facility failed to ensure cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 1 oxygen transfilling/storage room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.3 states storage for nonflammable gases with a total volume equal to or less than greater than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1 and 11.3.3.2. NFPA 99, Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect at least 20 residents, staff and visitors.<br><br>Findings include:<br><br>Based on observations on 10/17/22 between 1:45 p.m. and 4:30 p.m. during a tour of the facility with the Maintenance Director, there were two E size oxygen cylinders in the oxygen transfilling/storage room freestanding on the floor and were not supported in a proper cylinder stand or otherwise secured from falling. Based on interview at the time of the observation, the Maintenance Director acknowledged the two E size oxygen cylinders in the oxygen transfilling/storage room were not supported in a cylinder stand or otherwise secured from falling. | K 0923 | What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. Proper equipment was added to the O2 room to secure the Oxygen cylinders and the cylinders were secured.<br><br>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken. All residents have the potential to be affected by this practice. Proper equipment was added to the O2 room to secure the Oxygen cylinders and the cylinders were secured.<br><br>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. A check for O2 room for proper cylilnder storage was added to the daily interior rounds section of Building Engines. Nursing staff will be inserviced on proper O2 storage. | 11/17/2022 |

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| | This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.<br><br>3.1-19(b) | | How will the corrective action be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place. The results of the daily interior rounds will be reviewed monthly in the Quality Assurance meeting for six months or until no further corrective action is needed. | |