STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING -- B. WING	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGTON SKILLED NURSING FACILITY, THE	1500 GRANT ST HUNTINGTON, IN 46750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/01/2024 Facility Number: 000020 Provider Number: 155059 AIM Number: 100288696 At this Emergency Preparedness survey, The Waters of Huntington Skilled Nursing Facility was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 85 and had a census of 46 at the time of this survey. Quality Review conducted on 07/02/24	E 0000	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.	
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: 07/01/2024 Facility Number: 000020 Provider Number: 155059 AIM Number: 100288696 At this Life Safety Code survey, The Waters of Huntington Skilled Nursing Facility was found not in compliance with Requirements for Participation	K 0000	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bryce Tomasi	Administrator	07/15/2024

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

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	in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility 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, areas open to the corridors and battery powered smoke detection in the resident sleeping rooms. The facility has a capacity of 85 and had a census of 46 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review conducted on 07/02/24		allegation of substantial compliance with Federal Medicare and Medicaid requirements.	
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.			

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	18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted			

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	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 Based on observation and interview, the facility failed to ensure 3 of over 5 exterior exit doors were readily accessible and able to open on first try. This deficient practice could affect all occupants in the facility. Findings include: Based on observations and interviews during a tour of the facility with the Administrator and Maintenance Supervisor (MS) on 07/01/24 between 11:30 a.m. and 1:30 p.m., the following exit doors required excessive force and pressure to open the doors at the time of survey, Exit #9, Exit #6 and Exit #11. The MS stated that the aforementioned doors had been an issue due to decay and weather and were in need of being replaced. Door # 6 was able to open after several tries and the MS kicking the door. After several tries and considerable effort exit doors #9 and #6 were also eventually opened. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of discovery and again at the exit conference. 3.1-19(b)	K 0222	CORRECTIVE ACTIONS TAKEN: On 7/30/2024 the Maintenance Supervisor/designee repaired the doors at exit #9, 6 & 11 to ensure they are readily accessible and able to open on first try to meet set standards. The Administrator verified the work on 7/30/ ALL OTHERS WITH POTENTIAL TO BE AFFECTED: On 7/30/2024 the Maintenance Supervisor/designee inspected all doors and found no other negative findings. MEASURES TO PREVENT REOCCURRENCE: On 7/15/2024 the Administrator the Maintenance Supervisor/designee/ all staff to ensure exterior doors are readily accessible and able to open on first try to meet set standards. Maintenance Supervisor/designee will ensure exterior doors are readily accessible and able to open on first try as a part of the facility's Weekly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the	07/30/2024

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			inspection results. MONITORING CORRECTIVE ACTION: The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 7/30/2024.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of			

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	the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 2 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 5 staff and visitors. Findings include: Based on observations and interviews during a tour of the facility with the Administrator and Maintenance Supervisor (MS) on 07/01/24 between 11:30 a.m. and 1:30 p.m., the following was noted: A) The "Storage Room" near the front lobby, greater than 50 square feet, contained a number of combustible items, such as, paper, plastic, and cardboard boxes. The corridor doors (the room had two doors leading into the corridor, approximately 8 feet apart) to this room were not	K 0321	p paraid="1985506081" paraeid="{33482fe6-f90e-47fe-914c-d4feb9548556}{129}" > CORRECTIVE ACTIONS TAKEN: ·On 7/17/2024 the Maintenance Supervisor/designee installed a self-closing device on corridor door to the storage room near the front lobby to meet set standards. The Administrator verified the work on 7/17/2024. · On 7/15/2024 the Maintenance Supervisor/designee installed a self-closing device on corridor door	07/17/2024

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	equipped with a self-closing device. B) The "Housekeeping Storage / Old Office Area, greater than 50 square feet, had at least 17 cardboard boxes stored inside the room. The corridor door to this room was not equipped with a self-closing device or self-closing hinges. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of discovery and again at the exit conference. 3.1-19(b)		to the housekeeping storage/old office area to meet set standards. The Administrator verified the work on 7/15/2024. ·ALL OTHERS WITH POTENTIAL TO BE AFFECTED: ol class="NumberListStyle2 SCXW115940436 BCX8" role="list" start="1" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px; user-select: text; cursor: text; list-style-type: lower-alpha; overflow: visible;" MEASURES TO PREVENT REOCCURRENCE: ·On 7/12/2024 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure that all hazardous area doors are provided with a self-closing device to meet set standards. ·Maintenance Supervisor/designee will ensure that all hazardous area doors are provided with a self-closing device as a part of the facility's monthly Preventive Maintenance Program and document those inspection	

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			results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. ·The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance is in place. ·MONITORING CORRECTIVE ACTION: ·The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory	

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			requirements. Our date of compliance is 7/17/2024.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to install the kitchen range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 edition, Section 6.2.4.1 states kitchen range hood system filters shall be equipped with a drip tray beneath their lower	K 0324	K324– It is the intent of the facility to ensure to install the kitchen range hood system in accordance with the requirements of LSC 9.2.3 to meet set standards. 1. CORRECTIVE ACTIONS TAKEN: a. /17/2024 the Administrator/designee placed 3	07/17/2024

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	edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). This deficient practice could affect up to 6 staff in the kitchen area. Findings include: Based on observations and interviews during a tour of the facility with the Administrator and Maintenance Supervisor (MS) on 07/01/24 between 11:30 a.m. and 1:30 p.m., the design of the kitchen hood requires four drip trays, two on each side. Only the right side contained a (1) drip tray, 3 of the 4 were missing the metal drip trays underneath the kitchen range hood system. The MS stated he had not previously noticed that the hood system was missing 3 of the 4 drip trays. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of discovery and again at the exit conference. 3.1-19(b)		additional drip trays to the kitchen range hood system to meet set standards. The Administrator verified the work on 7/17/2024. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED: a residents and all staff and visitors have the potential to be affected but none were. 3. MEASURES TO PREVENT REOCCURRENCE: a. On 7/15/2024 the Administrator the Maintenance Supervisor/Dietary Manager and all dietary staff on the requirement to ensure the kitchen range hood system has all 4 metal drip trays installed to meet set standards. b. Maintenance Supervisor/Dietary Manager will ensure the kitchen range hood system has all 4 metal drip trays installed as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c Administrator will monitor adherence to the Preventative	

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			Maintenance schedule and validate the Preventative Maintenance is in place. 4. MONITORING CORRECTIVE ACTION: a. The monitoring results will be presented by the Administrator at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 7/17/2024.	
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6			

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	Based on record review and interview, the facility failed to provide a complete written policy for the protection of all residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review and interview with the Administrator and Maintenance Supervisor (MS) on 07/01/24 between 9:15 a.m. and 11:30 a.m., the fire watch plan failed to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Administrator acknowledged the fire watch documentation provided stated to contact the Indiana State Department of Health without a phone number, and not via the ISDH Gateway link or at the e-mail address listed above. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of discovery when a copy of the incomplete document was given to the surveyor, and again at the exit conference. 3.1-19(b)	K 0346	K346– It is the intent of the facility to ensure to provide a complete written policy for the protection of all residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6 to meet set standards. CORRECTIVE ACTIONS TAKEN: ·On 7/8/2024 the Administrator/Maintenance Supervisor updated the fire watch plan to include contacting the Indiana State Department of Health via the Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH gateway is nonoperational by completing the Incident Reporting form and emailing it to incidents@isdh.in.gov meet set standards. The Administrator verified the work on 7/8/2024. ·ALL OTHERS WITH POTENTIAL TO BE AFFECTED: . ·MEASURES TO PREVENT REOCCURRENCE:	07/08/2024

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			·On 7/8/2024 the Administrator in serviced the Maintenance Supervisor/DON/designee on the requirement to ensure the fire watch plan includes contacting the Indiana State Department of Health via the ISDH gateway link or by secondary method when the gateway link is nonoperational by emailing to incidents@isdh.in.gov to meet set standards. ·Maintenance Supervisor/DON/designee will ensure the fire watch plan includes contacting the Indiana State Department of Health via the ISDH gateway link or by secondary method when the gateway link is nonoperational by emailing to incidents@isdh.in.gov as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. ·The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance is in place.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGTON SKILLED NURSING FACILITY, THE	1500 GRANT ST HUNTINGTON, IN 46750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			·MONITORING CORRECTIVE ACTION: ·The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 7/8/2024.	
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities			

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	having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide correct written policies for the protection of all residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on records review and interview with the Administrator and Maintenance Supervisor (MS) on 07/01/24 between 9:15 a.m. and 11:30 a.m., the fire watch plan failed to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the	K 0354	p="" paraid="829140035" paraeid="{305442ff-76db-4725-ab53-a0253057739e}{111}">K354– It is the intent of the facility to ensure to provide correct written policies for the protection of all residents in the event the automatic sprinkler system be placed out of service for 10 hours or more in a period in accordance with LSC, Section 9.7.5 to meet set standards. CORRECTIVE ACTIONS TAKEN: On7/8/2024 the Administrator/Maintenance Supervisor updated the fire watch plan to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH gateway is nonoperational by completing the Incident Reporting form and emailing it to incidents@isdh.in.gov meet set standards. The Administrator verified the work on 7/8/2024. ALL OTHERS WITH POTENTIAL TO BE AFFECTED: ol="" role="list" start="1"	07/08/2024

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	primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Administrator acknowledged the fire watch documentation provided stated to contact the Indiana State Department of Health without a phone number, and not via the ISDH Gateway link or at the e-mail address listed above. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of discovery when a copy of the incomplete document was given to the surveyor, and again at the exit conference. 3.1-19(b)		MEASURES TO PREVENT REOCCURRENCE: On 7/8/2024 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure the fire watch plan includes contacting the Indiana State Department of Health via the ISDH gateway link or by secondary method when the gateway link is nonoperational by emailing to incidents@isdh.in.gov to meet set standards. Maintenance Supervisor/designee will ensure the fire watch plan includes contacting the Indiana State Department of Health via the ISDH gateway link or by secondary method when the gateway link is nonoperational by emailing to incidents@isdh.in.gov as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance is in place. MONITORING CORRECTIVE ACTION: The inspection results will be presented by the Maintenance Supervisor/designee to the	

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			Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 7/8/2024.	
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. 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			

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	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 4 of over 30 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 6 staff and 6 residents. Findings include: Based on observations and interviews during a tour of the facility with the Administrator and Maintenance Supervisor (MS) on 07/01/24 between 11:30 a.m. and 1:30 p.m., the following corridor doors failed to latch positively into their respective door frames: a) The "Miscellaneous Storage Room" on the East Hall - equipped with a self-closing device. b) The Therapy Equipment Room - - equipped with a self-closing device.	K 0363	p paraid="1042071753" paraeid="{305442ff-76db-4725-ab53-a0253057739e}{245}" > CORRECTIVE ACTIONS TAKEN: ·On 7/15/2024 the Maintenance Supervisor/designee made repairs to corridor door Miscellaneous Storage Room on the East Hall to ensure it latches positively into the door frame to meet set standards. The Administrator verified the repairs on 7/15/2024. ·On 7/15/2024the Maintenance	07/15/2024

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	c) Resident Room #306 d) Resident Room #310 This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of discovery and again at the exit conference. 3.1-19(b)		Supervisor/designee made repairs to corridor door Therapy Equipment Room to ensure it latches positively into the door frame to meet set standards. The Administrator verified the repairs on 7/15/ ·On 7/15/2024the Maintenance Supervisor/designee made repairs to corridor door Resident room 306 to ensure it latches positively into the door frame to meet set standards. The Administrator verified the repairs on 7/15/ ·On 7/15/2024 the Maintenance Supervisor/designee made repairs to corridor door Resident Room 310 to ensure it latches positively into the door frame to meet set standards. The Administrator verified the repairs on 7/15/2024. ·ALL OTHERS WITH POTENTIAL TO BE AFFECTED: · The Maintenance Supervisor/designee inspected all doors and found no other negative findings. ·MEASURES TO PREVENT REOCCURRENCE:	

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			·On 7/15/2024 the Administrator in serviced the Maintenance Supervisor/and all other staff members on the requirement to provide corridor doors that would close completely and latch positively into the frame to meet set standards. ·Maintenance Supervisor/designee will inspect all doors throughout the facility monthly to ensure corridor doors latch positively into the frame as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. ol class="NumberListStyle2 SCXW158631361 BCX8" role="list" start="3" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px; user-select: text; cursor: text; list-style-type: lower-alpha; overflow: visible;" The Administrator will monitor adherence to the Preventative Maintenance schedule and	

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			validate the Preventative Maintenance is in place. MONITORING CORRECTIVE ACTION: ·The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 7/15/2024.	
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.			

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	Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 5 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect 17 residents and staff. Findings include: Based on observations and interviews during a tour of the facility with the Administrator and Maintenance Supervisor (MS) on 07/01/24 between 11:30 a.m. and 1:30 p.m., the set of smoke barrier doors within the memory care unit did not close completely and latch. The MS worked on the latching mechanism during the survey and stated he was unaware the door set did not latch. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of discovery and again at the exit conference. 3.1-19(b)	K 0374	CORRECTIVE ACTIONS TAKEN: ·On 7/8/2024 the Maintenance Supervisor/designee made repairs to the smoke barrier doors within the memory care unit to ensure they close completely and latch to meet set standards. The Administrator verified the repairs on 7/8/ ·ALL OTHERS WITH POTENTIAL TO BE AFFECTED: · On 7/8/2024 the Maintenance Supervisor/designee inspected all smoke barrier doors throughout the facility and found no other negative findings. ·MEASURES TO PREVENT REOCCURRENCE: ·On 7/8/2024 the Administrator in serviced the Maintenance	07/08/2024

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			Supervisor/designee and all staff the requirement that smoke barrier doors must close completely and latch to meet set standards. ·Supervisor/designee will inspect all smoke barrier doors throughout the facility monthly to ensure they close completely and latch as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. ·The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance is in place. ·MONITORING CORRECTIVE ACTION: ·The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting.	

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			Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 7/8/2024.	