STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155162	A. BUILDING -- B. WING	07/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN RIDGE REHABILITATION CENTRE	600 WASHINGTON AVE WABASH, IN 46992

(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: 7/19/22 Facility Number: 000081 Provider Number: 155162 AIM Number: 100289570 At this Emergency Preparedness survey, Autumn Ridge Rehabilitation Centre was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 75 and had a census of 47 at the time of this survey. Quality Review completed on 07/28/22	E 0000		
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:			

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

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

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

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

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

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	is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next			

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

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

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

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	*[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or	E 0039	It is the intent of this facility that the facility will conduct exercises to test the emergency plan at least annually. This will include a full-scale community-based exercise as well as the tabletop exercise. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The required annual testing will be conducted, and appropriate documentation will be completed with each exercise. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All dependent residents have the	08/17/2022

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	c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator and the Maintenance Director on 07/19/22 at 1:00 p.m., there was documentation for an actual event for 2022, but documentation of an additional annual exercise of choice within the last year was not available for review. Based on interview at the time of records review, the Administrator stated the facility did do a tabletop exercise in February of 2022 but could not locate the documentation. The finding was reviewed with the Administrator during exit conference.		potential to be affected by the deficient practice. The facility conducted a Tabletop exercise 8/8/22. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Maintenance Supervisor or designee will formulate a schedule (using the TELS facility preventive maintenance software) in which the required exercises will be completed timely. The Executive Director/designee will review all Emergency Preparedness documentation to ensure it has been completed fully after each emergency exercise. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;and** On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. The Emergency Preparedness Testing Requirement QAPI tool will be completed weekly x 4 weeks, monthly x 3 months, and quarterly there after until compliance is achieved. If Threshold of 90% is not met an	

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			action plan will be developed to ensure compliance. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** **8/17/22**	
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: 07/19/22 Facility Number: 000081 Provider Number: 155162 AIM Number: 100289570 At this Life Safety Code survey, Autumn Ridge Rehabilitation Centre was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.	K 0000		

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	This three story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridor and hard wired smoke detectors in 9 resident rooms and the remaining resident rooms had battery operated smoke detectors. The facility has a capacity of 75 and had a census of 47 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except two detached sheds used for storage of maintenance parts. Quality Review completed on 07/28/22			
K 0222 SS=E 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. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6			

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	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 on door assemblies in buildings protected throughout by an approved, supervised			

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	155162	A. BUILDING 01 B. WING	07/19/2022

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	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 1 of 1 delayed egress locks signs was of proper size and location. LSC 7.2.1.6.1.(3)(4) states a readily visible, durable sign in letters not less than 1 in. (25mm) high and not less than 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect staff on the storage hall. Findings include: Based on observations during tour of the facility with the Maintenance Director on 07/19/22 at 12:15 p.m., the stair door exit located in the storage hall was provided with a delayed egress lock, but the signage indicating the door could be opened in 15 seconds by pushing the door was too small, hard to read, was located above the keypad, and not on the door. Based on interview at the time of observation, the Maintenance Director acknowledged the door was equipped with a delayed egress and lacked the proper signage. The finding was reviewed with the Administrator during the exit conference. 3.1-19(b)	K 0222	It is the intent of this provider to maintain compliance with the regulations for means of egress, including doors not have a lock that requires the use of a use a tool or key from the egress side. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The sign located on the stair door located in the storage hall has been changed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by this deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Maintenance Supervisor or designee will complete an in-house audit of all egress doors to ensure further compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	08/17/2022

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			recur, i.e., what quality assurance program will be put into place;and On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. Maintenance Supervisor or designee will document on the Egress Doors QAPI tool on weekly x 4 weeks, monthly x 3 months, and quarterly there after until compliance is achieved. If Threshold of 90% is not met an action plan will be developed to ensure compliance. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** **8/17/22**	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous			

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	illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 1 Sunroom courtyard door to the outside of the facility would not be mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 5 residents in the sun room. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 07/19/22 at 11:22 p.m., the Sunroom door to the enclosed courtyard that did not lead to the public way was not posted with a "NO EXIT" sign. Based on interview at the time of the observations, the Maintenance Director stated the courtyard is not an exit to the public way and acknowledged the door did not have a "NO EXIT" sign posted. The finding was reviewed with the Administrator during exit conference. 3.1-19(b)	K 0293	It is the intent of this provider to have an emergency preparedness communication plan that complies with Federal, State, and local laws. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Maintenance director put a NO Exit sign on the sunroom door leading to outside courtyard. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by this deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Maintenance Supervisor or designee will audit area to ensure the exit sign stays in proper placement. **How the corrective action(s) will be monitored to ensure the**	08/17/2022

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			deficient practice will not recur, i.e., what quality assurance program will be put into place;and On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. Maintenance Supervisor or designee will document on Sunroom QAPI tool on weekly x 4 weeks, monthly x 3 months, and quarterly there after until compliance is achieved. If Threshold of 90% is not met an action plan will be developed to ensure compliance. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** **8/17/22**	
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including			

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	exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ Based on observation and interview, the facility failed to ensure 1 of 3 smoke barriers was provided with a complete interior finish with a flame spread rating of Class A or Class B for a sprinklered facility. LSC 3.3.90.4 defines interior wall finish as the interior finish of columns, fixed or movable walls, and fixed or movable partitions. A.3.3.90.2 states interior finish is not intended to apply to surfaces within spaces such as those that are concealed or inaccessible.. This deficient practice could affect 15 residents on the second floor. Findings include: Based on observation with the Maintenance Director on 07/19/22 at 12:30 p.m., one third of the smoke barrier above the ceiling tiles on the cottage side of the second-floor 30-minute smoke barrier wall had missing drywall which exposed the untreated wood 2x4 studs for the wall.. Based on interview at the time of observation, the Maintenance Director agreed one side of the wall had exposed 2x4s and acknowledged the flame spread rating of the exposed wood studs was not known. 3.1-19(b)	K 0331	It is the intent of this provider to have an emergency preparedness communication plan that complies with Federal, State, and local laws. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Facility requesting temporary construction waiver. Facility having contractor come in to fix wall. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Maintenance Director and Executive Director toured facility to identify all areas that have smoke barrier walls. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Maintenance Supervisor/designee/Executive Director will review any future	08/17/2022

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			smoke barrier walls to ensure the appropriate finish. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;and** Maintenance Supervisor or designee will complete Fire QAPI tool on weekly x 4 weeks, monthly x 3 months, and quarterly there after until compliance is achieved. If Threshold of 90% is not met an action plan will be developed to ensure compliance. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** **8/17/22**	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of			

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	Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain the ceiling construction of 1 of 3 floors. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice affects 10 residents that use the first-floor therapy and dining room. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 07/19/22 at 11:50 p.m., in the suspended ceiling by the 2nd service hall exit, the closet, and the conference room the ceiling tiles were warped or broken leaving gaps in the suspended ceiling. This condition could delay the activation of the sprinklers installed on the suspended ceiling. Based on interview at the time of the observations, the Maintenance Director agreed there were gaps in the drop ceiling.	K 0353	It is the intent of this provider to have an emergency preparedness communication plan that complies with Federal, State, and local laws. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Tile was replaced by Maintenance Director. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Maintenance Director audited facility and replaced ceiling tiles that were warped or broken. All residents have the potential to be affected. **What measures will be put into place and what systemic changes will be made to**	08/17/2022

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	The finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		**ensure that the deficient practice does not recur;** Maintenance Director will add to TELS monitor system and add to routine maintenance **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;and** QA tool will be utilized weekly x 4 weeks, monthly x 3 months, and quarterly there after until compliance is achieved. If Threshold of 90% is not met an action plan will be developed to ensure compliance. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** **8/17/22**	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction			

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	2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observations, and interview, the facility failed to ensure 1 of 3 smoke barrier walls were constructed to requirements according to the authority having jurisdiction (AHJ). LSC 8.2.3.1 states the fire resistance of structural elements and building assemblies shall be determined in accordance with test procedure set forth in ASTM E 119, Standard Test Methods for Fire Tests of Building Construction and Materials, or ANSI/UL 263, Standard for Fire Tests of Building Construction and Materials; other approved test methods; or analytical methods approved by the AHJ. The AHJ requires penetrations in smoke barriers to be sealed with a firestop system or device tested in accordance with ASTM E 814. This deficient practice could affect 15 residents on the second floor. Findings include: Based on observation with the Maintenance Director on 07/19/22 at 12:30 p.m., above the ceiling tiles of the second-floor smoke barrier wall the wires through the wall were sealed with joint compound and not a rated fire stop material in accordance with ASTM E 814. Based on interview at the time of observation, the Maintenance Director agreed the penetrations were sealed with	K 0372	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The joint compound was replaced with a rated fire stop material. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance Director will complete an in-house audit of all smoke barriers to ensure compliance. The Maintenance Director sealed the wires listed on the 2567 with fire caulk. **How the corrective action(s)**	08/17/2022

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	joint compound. The findings were reviewed with the Administrator during the exit conference. 3.1-19(b)		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;and** Maintenance Director or Designee will complete the Smoke Barriers QAPI tool weekly x 4 weeks, monthly x 3 months, and quarterly there after until compliance is achieved. If Threshold of 90% is not met an action plan will be developed to ensure compliance. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** **8/17/22**	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous			

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	location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview; the facility failed to ensure 1 of 1 smoking areas were maintained by disposing only cigarette butts in the metal container with a self-closing cover. This deficient practice could affect 20 staff and at least 1 resident. Findings include: Based on observation during a tour of the facility with Maintenance Director on 07/19/22 at 12:20 p.m., in the staff smoke shack the cigarette butt disposal container was mixed combustible cigarette packages. Based on interview at the time of observation, the Maintenance Director agree cigarette butts and combustible items were in the cigarette butt disposal container.	K 0741	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Maintenance Director removed cigarette packages from the cigarette butt disposal container. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected. **What measures will be put into place and what systemic**	08/17/2022

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	The finding was reviewed with the Administrator during exit conference. 3.1-19(b)		**changes will be made to ensure that the deficient practice does not recur;** Sign posted to dispose of cigarettes in the smoking receptacle only. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;and** Maintenance Director or Designee will complete QAPI tool weekly x 4 weeks, monthly x 3 months, and quarterly there after until compliance is achieved. If Threshold of 90% is not met an action plan will be developed to ensure compliance. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** **8/17/22**	