STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155356	A. BUILDING -- B. WING	03/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSITIONAL CARE UNIT OF ST JOSEPH	700 BROADWAY TRANSITIONAL CARE UNIT FORT WAYNE, IN 46802

(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 State Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/08/18 Facility Number: 000247 Provider Number: 155356 AIM Number: N/A At this Emergency Preparedness survey, Transitional Care Unit of St Joseph was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 20 certified beds. At the time of the survey, the census was 15. Quality Review completed on 03/15/18 - DA The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	This facility is requesting paper compliance	
E 0022 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a means to shelter in place for residents, staff, and volunteers who remain in the LTC facility in accordance with 42 CFR 483.73(b)(4). This deficient practice could affect all occupants.	E 0022	Reason for IDR The Emergency Operations Plan (Policy EM.02.01.01.2 and Sustainability Policy EM.02.01.01.3) was previously implemented and has been revised annually and if needed following	04/07/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155356	A. BUILDING -- B. WING	03/08/2018

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TRANSITIONAL CARE UNIT OF ST JOSEPH	700 BROADWAY TRANSITIONAL CARE UNIT FORT WAYNE, IN 46802

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	Findings include: Based on record review and interview with the Administrator and the Facilities Manager on 03/08/18 at 11:42 a.m., a policy and procedure that included a means to shelter in place for residents, staff, and volunteers who remain in the LTC facility was not available for review.		results of After Action report for each exercise. The Transitional Care Unit (Skilled Nursing) of St. Joseph Hospital follows the Hospital policy on Emergency Preparedness. (page 22 and 23 of the EOP). The Plan and policies include shelter in place for residents, staff, and volunteers. The Emergency Operations Plan was effective and offered during the March 8, 2018 Transitional Care Unit of St Joseph Hospital Life Safety Code with Emergency Preparedness Survey. Surveyor acknowledged that the Plan was present during interview with TCU Administrator and Emergency Preparedness Coordinator, however, declined to the opportunity to review. **I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Emergency Management Coordinator to re-educate TCU staff on the established Emergency Operations Plan and their role in the event of an emergency to ensure resident, staff and volunteer safety while sheltering in place by 04/07/2018. This will be accomplished by discussion at unit meetings, reflection in meeting minutes, participation in exercises and	

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			trainings and through completion of annual ALC lessons. **II. 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;** Re-educate TCU staff on the established Emergency Operations Plan and their role in the event of an emergency to ensure resident, staff and volunteer safety while sheltering in place by 04/07/2018. This will be accomplished by discussion at unit meetings, reflection in meeting minutes, participation in exercises and trainings and through completion of annual ALC lessons. **III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Director of Nursing or designee to ensure TCU staff continued participation in emergency preparedness exercises, during new hire departmental orientation and completion of annual online education lessons.	

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			IV. 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; 1.The Director of Nursing or designee is tracking annual education and participation in exercises annually that test the EOP. 2.Emergency Management Coordinator facilitate completion of After Action Reports (AAR) and exercise critique following all exercises and real world events that take place in the facility and will be presented during the quarterly Quality Assurance Performance Improvement meeting. - - **V. By what date the systemic changes will be completed.** Date Systemic Changes will be completed by April 7 2018	
E 0026 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.73(b)(8).	E 0026	**Reason for IDR** The Emergency Operations Plan (Policy EM.02.01.01.0) and the Sustainability Policy	04/07/2018

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	This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Administrator and the Facilities Manager on 03/08/18 at 11:46 a.m., a policy and procedure for the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act was not available for review.		(EM.02.01.03) were previously implement and have been revised annually and if needed following results of After Action report for each exercise. The Transitional Care Unit (Skilled Nursing) of St Joseph follows the Hospital policy on Emergency Preparedness (page 22 and 23 of the EOP) Page eighteen (18) of the EOP indicates that daily financial reporting requirements are likely to be modified and, in select situations, new requirements outlined by State and Federal officials (which would include any waivers declared by the Secretary). The EOP outlines care, treatment and services. The Sustainability Policy (EM.02.01.03) identifies alternative care sites where care will be delivered. Those alternative sites include Lutheran Hospital, DuPont Hospital, Vibra Hospital, and the Boys and Girls Club of America. The Emergency Operations Plan, the Sustainability Policy, along with additional emergency management policies and procedures were effective and offered during the March 8, 2018 Transitional Care Unit of St Joseph Hospital Life Safety Code with Emergency Preparedness Survey. Surveyor acknowledged	

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			that the Plan was present during interview with TCU Administrator and Emergency Preparedness Coordinator, however, declined to the opportunity to review. Plan of Correction: **I. What corrective action(s) will be accomplished for those residents found to have been affected** **by the deficient practice;** Emergency Management Coordinator will re-educate TCU staff on the established Emergency Operations Plan and their role in the event a decision is made to execute plan for alternative care sites. This will be accomplished by discussion at unit meetings, reflection in meeting minutes, participation in exercises and trainings and through completion of annual ALC lessons. This will be accomplished by April 7 2018 **II. 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;** Emergency Management	

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			Coordinator will re-educate TCU staff on the established Emergency Operations Plan and their role in the event a waiver is declared by the Secretary and if any modifications of current requirements need to be made during the Emergency. This will be accomplished by discussion at unit meetings, reflection in meeting minutes, participation in exercises and trainings and through completion of annual ALC lessons. This will be accomplished by April 7 2018 **III. What measures will be put into place or what systemic changes will be made to ensure that** **the deficient practice does not recur;** Director of Nursing or designee to ensure TCU staff continued participation in emergency	

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			preparedness exercises, during new hire departmental orientation and completion of annual online education lessons. **IV. 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;** The Director of Nursing or designee is tracking annual education and participation in exercises annually that test the EOP. 1.Emergency Management Coordinator facilitate completion of After Action Reports (AAR) and exercise critique following all exercises and real world events that take place in the facility. 2.Emergency management will be added to the quarterly Quality Assurance Performance Improvement program agenda as one of the Performance Initiatives for 2018. **V. By what date the systemic changes will be completed.**	

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			Date Systemic Changes will be completed by April 7 2018	

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/08/18 Facility Number: 000247 Provider Number: 155356 AIM Number: N/A At this Life Safety Code survey, Transitional Care Unit of St. Joseph was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(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. The facility has elected to utilize a Categorical Waiver pertaining to electric motor driven fire pump	K 0000	This facility is requesting paper compliance	

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	assemblies and is in compliance. The Transitional Care Unit was fully sprinklered and located on the ninth floor of an ten story partially sprinklered hospital of Type I (332) construction. The facility has a fire alarm system with smoke detection in the areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 20 and had a census of 15 at the time of this survey. Quality Review completed on 03/15/18 - DA			
K 0211 SS=F Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to maintain 1 of 2 corridors from obstructions per 19.2.1 LSC 19.2.1 states that every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. LSC 7.1.10. Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. LSC 7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits or their access thereto, egress therefrom, or visibility thereof. This deficient practice could affect all occupants. Findings include:	K 0211	**I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The deficient practice was immediately addressed by the Administrator on 03/08/2018 by ensuring the three soiled linen carts and one clean linen cart were removed from the hallway thus ensuring means of egress is continuously maintained free of obstructions in case of an emergency.	04/07/2018

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	Based on observation with the Administrator and the Facilities Manager on 03/08/18 at 12:23 p.m., three separate soiled linen carts and one clean linen cart were in the corridor outside resident room 917. Based on interview at the time of observation, the Administrator and the Facilities Manager acknowledged the soiled and clean linen carts were potential impediments to full use of the means of egress access corridors. 3.1-19(b)		**II. 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;** The deficient practice was immediately addressed by the Administrator by ensuring the three soiled linen carts and one clean linen cart were removed from the hallway thus ensuring means of egress is continuously maintained free of obstructions in case of an emergency. All other residents had the potential of being affected by the deficient practice. Therefore, the entire hallway was observed on 03/08/2018 for obstructions and no additional deficiencies noted. **III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** To ensure that the deficient practice does not recur, the following will be done: 1.All TCU staff will be educated on Chapter 7 of NFPA 101 (specifically as it relates to maintaining hallways free of obstructions) by 04/07/2018. 2.Starting 03/26/2018, Director	

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			of Nursing or designee will perform random audit once daily for 21 days (21 audits) followed by random audit 3 times a week X 2 weeks (6 audits), then 1 random audit/ week for 8 weeks will be done to maintain 100% compliance to ensure corridors are free of all obstructions. 3.All new hires will be educated by the Director of Nursing or designee to ensure compliance. **IV. 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;** 1.The Director of Nursing or designee will address any deviations immediately with the charge nurse. 2.The result of the audit will be shared with staff during the Monthly Department Meeting. 3.The audit result will be reviewed during the Quarterly Quality Assurance Meeting. 4.The deficient practice will be added to the Quality Assurance Performance Improvement program as one of the Performance Initiatives for the 2nd and 3rd quarter of 2018. **V. By what date the systemic changes will be completed.** Date Systemic Changes will be completed by April 7 2018	

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K 0311 SS=F Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. Based on observation and interview, the facility failed to maintain protection of 2 of 3 stairways in accordance of 19.3.1. LSC 19.3.1.1 requires where an enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating. This deficient practice could affect all occupants. Findings include: Based on observation with the Administrator and the Facilities Manager on 03/08/18 at 12:28 p.m. then again at 1:34 p.m., stairway #2 contained a three quarter inch gap around a pipe on the top floor. Then again, the Center stairway contained a storage room. The storage room door was not self-closing. Based on interview at the time of each observation, the Administrator and the Facilities Manager acknowledged the gap around the pipe; provided the measurement and confirmed the storage room door did not self-close. 3.1-19(b)	K 0311	**I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** 1.Stairway # 2 contained a three quarter inch gap around the pipe on the top floor. This deficient practice was immediately corrected by creating a work order #338148 to fire caulk around the penetration through the fire wall. This work order was completed on Friday the 16th of March. 2.The Center stairway # 1 contained a storage room that was not self-closing. The deficient practice was immediately corrected by creating a work order on 03/19/2018 #338218. The work order was completed on the same day (03/19/2018). **II. How other residents having the potential to be affected by the same deficient practice will**	04/07/2018

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			be identified and what corrective action(s) will be taken; 1.Stairway # 2 contained a three quarter inch gap around the pipe on the top floor. This deficient practice was immediately corrected by creating a work order # 338148 to fire caulk around the penetration through the fire wall. This work order was completed on Friday the 16th of March. The 2 other stairways were also re-inspected and they are fully sprinkled. 2.The Center stairway # 1 contained a storage room that was not self-closing. The deficient practice was immediately corrected by creating a work order on 03/19/2018 #338218. The work order was completed on 03/20/2018. Other storage areas were inspected and no issues identified. 3.This deficient practice could affect all residents. Therefore, all other stairwells were inspected for similar deficiencies and found to be compliant **III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** 1.Stairway # 2 - Security / Operator staff will be reeducated	

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TRANSITIONAL CARE UNIT OF ST JOSEPH	700 BROADWAY TRANSITIONAL CARE UNIT FORT WAYNE, IN 46802

(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
			to ensure that vendors comply with the existing Above Ceiling Work Permit (Policy Number EC.02.03.01.1.b) and complete the necessary paperwork before initiating work in the facility. Once work is completed, the vendor needs to let Security/Operator know that the work is completed. The Security/Operator will notify Facilities who will inspect to ensure fire wall penetration is completed properly. 2.Stairway # 1 – This storage room door will be added to the Quarterly inspection checklist performed by Facilities technician which will be completed and documented once every quarter to ensure that the door closure functions properly. **IV. 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;** 1.Stairway # 2 - Starting 03/26/2018, Facilities Manager or designee will perform random audit once daily for 4 weeks, followed by random audit 3 times a week X 2 weeks (6 audits), then 1 random audit/ week for 8 weeks will be done to maintain 100% compliance to ensure fire wall penetration policy is followed. 2.Stairway # 1- Quarterly inspections will be completed and	

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			documented by Facilities technician to ensure that the door closure functions properly. 3.The audit result will be reviewed during the Quarterly Quality Assurance Meeting. **V. By what date the systemic changes will be completed.** Date Systemic Changes will be completed by April 7 2018	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure complete sprinkler coverage in 1 of 3 Stairwells was installed in accordance with	K 0351	**I What corrective action(s) will be accomplished for those residents found to have been**	04/07/2018

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	9.7.1.1. This deficient practice could affect staff and up to 5 residents. Findings include: Based on observation with the Administrator and the Facilities Manager on 03/08/18 at 12:40 p.m., there was no sprinkler coverage in the Stair 13. Based on interview at the time of observation, the Administrator and the Facilities Manager confirmed no sprinkler head was at the top of the stairwell. 3.1-19(b)		**affected by the deficient practice;** 1.The deficient practice was immediately addressed by the Facility Manager who contacted the Current Fire Protection Company. They assessed the area and the quote to install Sprinkler head(s) at the top of the Stairway 13 will be provided by March 21st and installation will be completed by April 7 2018 **II. 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;** 1.Sprinkler head(s) will be installed and wall mounted at the top of the Stairway 13 by April 7 2018 2.This deficient practice could affect staff and up to 5 residents. All other stairwells were inspected for similar deficiencies and found to be compliant. **III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** 1.It will be a permanently installed sprinkler head(s) to ensure deficient practice doesn't	

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			recur and to improve patient safety. **IV. 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;** 1.The new sprinkler head(s) will be tied into the existing fire alarm system and they will be monitored with our existing monitoring system in the Security Booth **V. By what date the systemic changes will be completed.** Date Systemic Changes will be completed by April 7 2018	
K 0363 SS=F 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			

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	covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to maintain protection of corridor doors in 1 of 2 corridors in accordance of 19.3.6.3. This deficient practice could affect all occupants. Findings include: Based on observation with the Administrator and the Facilities Manager on 03/08/18 at 12:32 p.m., resident room 905 failed to latch when tested. Based on interview at the time of observation, the Administrator and the Facilities Manager acknowledged the corridor door failed to latch into the frame. 3.1-19(b)	K 0363	**I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The Resident room 905 failed to latch when tested during the survey. This deficient practice was immediately corrected by creating a Maintenance work order # 338146 for on 03/15/2018 to ensure door latches. This work order was completed by Facility Technician on 03/19/2018. **II. How other residents having**	04/07/2018

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			the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; This deficient practice could affect all occupants. Therefore, a Maintenance work order 338223 was created to ensure all other Resident Room doors on the Transitional Care Unit latch per policy. This was completed by Facilities technician on 03/19/2018 and 100% compliance was observed and documented. **III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** 1.TCU Staff will be educated by Director of Nursing or designee on the life safety policy for ensuring complete latching of the resident room doors when closed. 2.The TCU staff will perform audits during the monthly fire drills to ensure positive latching of all the doors. 3.The Facilities personnel will continue to perform annual audit of all resident room doors to ensure 100% compliance with latching the doors when closed.	

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			IV. 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; 1.The results of the monthly audit by staff will be shared during the Monthly Unit Meeting and at the Quarterly Quality Assurance Meeting. **V. By what date the systemic changes will be completed.** Date Systemic Changes will be completed by April 7 2018	
K 0541 SS=D Bldg. 01	NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chu Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (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. (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. (3) Any trash chute shall discharge into a trash collection room used for no other			

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	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.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 Based on observation and interview, the facility failed to provide 1 of 1 laundry chute with self-closing openings. This deficient practice could affect staff only. Findings include: Based on observation with the Administrator and the Facilities Manager on 03/08/18 at 12:18 p.m., the Laundry chute door opening did not self-close when tested. Based on interview at the time of observation, the Administrator and the Facilities Manager confirmed no self-closure had been installed. 3.1-19(b)	K 0541	**I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The laundry chute door with self-closing openings was not working during the survey. This deficient practice was immediately corrected by placing a work order # 338165 to Facilities on 03/16/2018. The broken closure was replaced by Facilities technician on 03/19/2018 and is functioning properly. **II. 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;** The laundry chute door with self-closing openings was not working during the survey. This deficient practice could affect staff only. This was immediately corrected by placing a work order # 338165 to Facilities on 03/16/2018. The broken closure	04/07/2018

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			was replaced by Facilities technician on 03/19/2018 and is functioning properly. **III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** 1.Transitional Care Unit Staff will be educated by the Director of Nursing or designee regarding the self-closing requirements of the laundry chute and will report any deviations and enter a work order immediately to Facilities for repair. 2.Director of Nursing or designee will complete random audit once a day X 4 weeks to ensure that the laundry chute door is self -closing 3.Monthly inspections will continue to be performed by Facilities technician to ensure the laundry chute door functions as designed. **IV. 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;** 1.The results of the daily audit by Director of Nursing or designee and monthly inspection by Facilities will be shared during the Monthly Unit Meeting and at the	

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			Quarterly Quality Assurance Meeting. **V. By what date the systemic changes will be completed.** Date Systemic Changes will be completed by April 7 2018	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affects all occupants. Findings include: Based on record review of the "Fire Drill/Incident Critique" form with the Administrator and the Facilities Manager on 03/08/18 at 10:20 a.m., three sequential first shift fire drills took place between 9:00 a.m. and 9:30 a.m. for three of the last four quarters. Then again, four sequential third shift fire drills took place between 2:25 a.m. and 3:00 a.m. for four of the last four quarters. Based on interview at the time of record review, the Administrator and the Facilities Manager	K 0712	**I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** This deficient practice was immediately corrected on March 19th 2018 by addressing it with the Security Supervisor whose staff is responsible for conducting the Fire Drills at unexpected times each month. **II. How other residents having the potential to be affected by**	04/07/2018

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	acknowledged the times of the fire drills times were not varied. 3.1-19(b) 3.1-51(c)		**the same deficient practice will be identified and what corrective action(s) will be taken;** This deficient practice affects all occupants. This deficient practice was immediately corrected on March 19th 2018 by addressing it with the Security Supervisor whose staff is responsible for conducting the Fire Drills at unexpected times each month. **III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** 1.Security Staff will be educated by Security Supervisor regarding the NFPA 101 guideline of conducting fire drills at expected and unexpected times under varying conditions, at least quarterly on each shift. This will be completed by April 7 2018 2.The Security Supervisor or designee will ensure an audit is completed after every fire drill on TCU X 6 months to ensure that the drills are conducted at unexpected times each month. **IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put into place; 1.The results of the quarterly audit by the Security Supervisor or designee will be shared during the Monthly Unit Meeting and at the Quarterly Quality Assurance Meeting. **V. By what date the systemic changes will be completed.** Date Systemic Changes will be completed by April 7 2018	
K 0920 SS=C Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been 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			

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	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 Based on record review and interview, the facility failed to ensure 1 of 1 emergency diesel powered generator was allowed a 5 minute cool down period after a load test. NFPA 110 8.4.5(4) requires a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shut down. This delay provides additional engine cool down. This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator and the Facilities Manager on 03/08/18 at 11:09 a.m., the generator log form documented the generator was tested monthly for at least 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. Based on interview at the time of record review, the Administrator and the Facilities Manager acknowledged the lack of documentation. 3.1-19(b)	K 0920	**I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The cool down time on both emergency diesel powered generators will be monitored and documented once a month by Facilities technician during the monthly load test to ensure a minimum of 5 minute cool down time per NFPA 110 8.4.5(4) guidelines. **II. 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;** This Deficient practice could affect all occupants. The cool down time on both emergency diesel powered generators will be monitored and documented once a month by Facilities technician during the monthly load test to ensure a minimum of 5 minute cool down time per NFPA 110 8.4.5(4) guidelines. **III. What measures will be put**	04/07/2018

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			into place or what systemic changes will be made to ensure that the deficient practice does not recur; The Facilities technician responsible for the load testing will be at the generators and timing/documenting the cool down period to ensure it meets the requirements of minimum of 5 minutes. The Facilities Manager or designee will be responsible to ensure that the documentation meets the NFPA standards. **IV. 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;** The audit result will be reviewed during the Quarterly Quality Assurance Meeting. **V. By what date the systemic changes will be completed.** Date Systemic Changes will be completed by April 7 2018	