STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155825	A. BUILDING -- B. WING	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ST AUGUSTINE HOME FOR THE AGED	2345 W 86TH ST INDIANAPOLIS, IN 46260

(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 Dates: 08/02/22 - 08/03/22 Facility Number: 000389 Provider Number: 155825 AIM Number: 100288920 At this Emergency Preparedness survey, St. Augustine Home for the Aged was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 42 certified beds. At the time of the survey, the census was 25. Quality Review completed on 08/08/22	E 0000		
E 0035 SS=C Bldg. --	483.475(c)(8), 483.73(c)(8) LTC and ICF/IID Sharing Plan with Patients §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an			

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

Steven M Still | Administrator | 03/11/2023

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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	emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. Based on record review and interview, the facility failed to ensure the emergency preparedness plan (EPP) includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Facilities Operations Manager and Assistant Maintenance Supervisor on 08/02/22 between 10:15 a.m. and 1:15 p.m., the Emergency Preparedness Binder provided did not address a method for sharing information contained within the EPP Binder that the facility deems appropriate with resdents, their families or representatives. Based on interview at the time of records review, the Facilities Operations Manager agreed the aforementioned policy was not in the provided EPP Binder. This finding was acknowledged by the Facilities Operations Manager and Assistant Maintenance Supervisor at the time of observation and again at the exit conference on 08/03/22 at 12:50 p.m.	E 0035	**E 035 Emergency Preparedness.** 1. What corrective actions will be accomplished for those found to have been affected by the deficient practice: A binder with the method of sharing communication plans from the emergency preparedness Plan (EPP) for Families or Representatives will be posted in the front reception area that is easily seen and accessible at all times. 2. 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 and residents families will have access to the emergency preparedness plan posted in the front reception area. Further the Facilities Operation Manager with the Facility Administrator will conduct quarterly meetings to review this policy with residents and resident's families. 3. What measures will be	09/03/2022

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			put into place and what systemic will be made to insure that the deficient practice does not recur . This Emergency preparedness plan will be held in our main emergency preparedness binder. It will be reviewed with attendees: residents and their representatives at quarterly care conferences. Further the plan will be monitored and signed off by our Emergency management team monthly. It will also be reviewed Quarterly by the QAPI committee overseen by Mother Superior and the administrator. Completion date 9/3/2022	
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 Dates: 08/02/22 - 08/03/22 Facility Number: 000389 Provider Number: 155825 AIM Number: 100288920 At this Life Safety Code survey, St. Augustine Home for the Aged 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 facility, located on the 2nd and 3rd floor of a three-story building, was determined to be of Type II (222) construction and was fully sprinklered except for 2 of 5 walk-in coolers in the kitchen. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident rooms. The entire 2nd and 3rd floors, including the Assisted Living sections were part of this survey as only smoke doors, no corridor fire doors separating the occupancies were present. The facility has a capacity of 42 and had a census of 25 at the time of this visit. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 08/08/22			
K 0131 SS=F Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance			

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	with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 Based on observation and interview, the facility failed to ensure 4 of 4 separation fire doors would positively latch to limit the spread of fire and restrict the movement of smoke. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.3.3.1 states openings required to have a fire protection rating shall be protected by approved, listed, labeled fire door assemblies installed in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, Section 6.1.4.2.1 states self-closing doors shall swing easily and freely and shall be equipped with a closing device to cause the door to close and latch each time it is opened. LSC 8.3.4.1 states every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. This deficient practice could affect all residents. Findings include: Based on observations and interview during a tour of the facility with the Facilities Operations Manager and Assistant Maintenance Supervisor on 08/02/22 between 1:15 p.m. and 4:15 p.m. and again on 08/03/22 between 9:30 a.m. and 12:30 p.m., the two sets of swinging double fire barrier doors separating the Skilled nursing from the Assisted Living occupancies, on the East and West wings of the 2nd and 3rd floors did not	K 0131	**K 131 Fire Doors.** 1. What corrective actions will be accomplished for those having been affected by this deficient practice: Fire doors and fire door closing device will be install by a certified door contractor on the 2nd and 3rd floors .At this time the Little Sisters would like to ask for a Temporary Waiver on this item for 6 months due to the cost of the doors and door hardware. Further, these items will take longer than usual timeframes to receive and to be able to complete this measure as there are supply chain issues in delivering the goods needed to complete this. A copy of the quote and lead times is uploaded under additional documentation. 2. What are the reasonable completion dates for all deficiencies prior to the termination date per the waiver that is requested? The 6-month Temporary Waiver request documents an end date of 02/03/2023. The completion date is 02/03/2023. Updated Temporary Waiver request documents an end date of	03/10/2023

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	close and latch. The Facilities Operations Manager and Assistant Maintenance Supervisor agreed the aforementioned doors did not have latching hardware. This finding was acknowledged by the Facilities Operations Manager and Assistant Maintenance Supervisor at the time of observation and again at the exit conference on 08/03/22 at 12:50 p.m. 3.1-19(b)		03/10/2023. Four of four separation fire doors have been replaced and installed as of 03/10/2023. 3. What is the procedure for implementing actions that will prevent recurrence and how will it be monitored? The installation of new fire doors will prevent future recurrence of the stated deficiency. For monitoring throughout the next six months until installation, the maintenance department will regularly monitor the fire doors. 4. Who is responsible for implementation and monitoring of the plan for future compliance with regulations. The Facility Operations Manager is responsible for the implementation and monitoring for compliance. The Manager will report quarterly to the QAPI Committee.	
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			

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	be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard 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.			

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	18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through the 2nd Floor stairwell exit was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 15, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview during a tour of the facility with the Facilities Operations Manager and Assistant Maintenance Supervisor on 08/02/22 between 1:15 p.m. and 4:15 p.m. and again on 08/03/22 between 9:30 a.m. and 12:30 p.m., the 2nd Floor stairwell Southeast Entrance exit door, marked as a facility exit, was magnetically locked and could be opened by entering a four-digit code but the code was not posted at the exit. This finding was acknowledged by the Facilities Operations Manager and Assistant Maintenance	K 0222	**K 222 Egress Doors** What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice: the four – digit code is now posted on the exit door touch pad to open the exit doors on the 2nd floor stairwell Southeast Entrance exit. Also the maintenance department will log this on a spread sheet. How other residents having the potential to be affected by the same deficient practice will be identified what corrective action(s) will be taken. The four –digit code is posted on the touch pad in plain view on the Southeast Entrance stairwell to exit and enter the stairwell door. 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 will do daily rounds to insure we stay compliant with the code.	09/03/2022

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	Supervisor at the time of observation and again at the exit conference on 08/03/22 at 12:50 p.m. 3.1-19(b)		Further, the Facilities Operations Manager will report on this at the quarterly QAPI committee meeting overseen by Mother Superior and the administrator to insure compliance. Completion date 9/3/2022	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of 8 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect 15 residents and staff using the East stairwell exit. Findings include: Based on observations and interview during a tour of the facility with the Facilities Operations Manager and Assistant Maintenance Supervisor on 08/02/22 between 1:15 p.m. and 4:15 p.m. and again on 08/03/22 between 9:30 a.m. and 12:30 p.m., the exit discharge from the East Stairwell Exit, had a 4-5-inch elevation change where the concrete pad met the blacktop and was uneven. Based on interview at the time of observation, the Facilities Operations Manager acknowledged that	K 0271	K271 Discharge from exit 1. What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice: A paving contractor will level that exit discharge on the East stairwell exit .removing that 4-5 inch elevation change . 2. 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 sidewalk will be leveled out to remove that 4-5 inch elevation change making that egress safe for all residents and staff to exit if	09/03/2022

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	the walkway was uneven and stated that new pavement was scheduled to begin soon. This finding was acknowledged by the Facilities Operations Manager and Assistant Maintenance Supervisor at the time of observation and again at the exit conference on 08/03/22 at 12:50 p.m. 3.1-19(b)		needed. 3. 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 Department will do weekly rounds to ensure this does not recur and will use a log sheet to track this . Further, the facility Operations Manager will report at the quarterly QAPI meetings overseen by Mother Superior and the Administrator. Completion date 9/3/2022	
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 the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9			

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	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 5 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 25 residents, as well as staff and visitors. Findings include: Based on observations and interview during a tour of the facility with the Facilities Operations Manager and Assistant Maintenance Supervisor on 08/02/22 between 1:15 p.m. and 4:15 p.m. and again on 08/03/22 between 9:30 a.m. and 12:30 p.m., the following was noted: A) Room 223, greater than 50 square feet, contained a number of combustible items, such as, 16 chairs and 3 beds. The corridor door to this room was not equipped with a self-closing device. B) Room 218, greater than 50 square feet, had at least 16 pallets containing cardboard boxes stored inside the room. The room not equipped with a self-closing device or self-closing hinges.	K 0321	K321 Hazardous Areas Enclosure What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Room 218,219,The shower room 2nd floor east hall,3rd floor library and 3rd medical room. Will have Self – closing device or self-closing hinges installed by a Certified door contractor. 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; Installing a self-closing device will protect all residents from smoke and contain a fire Further, a self-closing device will keep doors from being left open. What measures will be put into place and what systemic changes will be made to ensure that the	09/03/2022

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	C) Room 219, greater than 50 square feet, contained at least 6 pallets containing boxes and boxes of single use supplies. The room not equipped with a self-closing device or self-closing hinges. D) The shower room on 2nd floor East hall, greater than 50 square feet, equipped with a self-closing device, was propped open and did not self-close. E) The 3rd Floor Library, greater than 50 square feet, contained numerous books and wooden shelving. The room not equipped with a self-closing device or self-closing hinges. F) The 3rd Floor Medical room, where medications are stored, was not equipped with a self-closing device or self-closing hinges. This finding was acknowledged by the Facilities Operations Manager and Assistant Maintenance Supervisor at the time of observation and again at the exit conference on 08/03/22 at 12:50 p.m. 3.1-19(b)		deficient practice does not recur. The maintenance department will perform monthly checks and maintain a log to stay in compliance with the code The Facility Operations Manager will report at the quarterly QAPI committee meeting overseen by mother Superior and the administrator. Completion 9/3/2022	
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			

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(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
	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) 1. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 2010 Edition, Standard for the Installation of Sprinkler Systems to provide complete coverage for all portions of the building. NFPA 13, Section 8.1.1(1) states sprinklers shall be installed throughout the premises. This deficient practice could affect residents, staff and/or visitors in the vicinity of the 2nd Floor East Food Prep Area. Findings include: Based on observations and interview during a tour of the facility with the Facilities Operations Manager and Assistant Maintenance Supervisor on 08/02/22 between 1:15 p.m. and 4:15 p.m. and again on 08/03/22 between 9:30 a.m. and 12:30 p.m., the HVAC closet near the 2nd Floor East Food Prep Area lacked sprinkler protection. Based on interview at the time of observation, the Facilities Operations Manager acknowledged the lack of sprinkler protection in the HVAC furnace closet. This finding was acknowledged by the Facilities Operations Manager and Assistant Maintenance Supervisor at the time of observation and again at the exit conference on 08/03/22 at 12:50 p.m.	K 0351	K351 Sprinkler system Existing What corrective action(s) will be accomplished for those residents found by the deficient practice: Upon further investigation with our fire protection company (Koorsen Fire & security), the HVAC closet of the 2nd Floor East Food Prep area does have a sprinkler head in it. The 3rd Floor supply room closet sprinkler head items that were blocking it have been removed and the sprinkler head is now free of obstructions. 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 obstructions that where in front of the sprinkler head in the 3rd floor supply closet have been removed providing a safe storage area for all to use. What measures will be put into place and what systemic changes will be made to ensure that the	09/03/2022

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	155825	A. BUILDING 01 B. WING	08/03/2022

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	2. Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in the Supply Closet in accordance with 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect up to 3 staff. Findings include: Based on observations and interview during a tour of the facility with the Facilities Operations Manager and Assistant Maintenance Supervisor on 08/02/22 between 1:15 p.m. and 4:15 p.m. and again on 08/03/22 between 9:30 a.m. and 12:30 p.m., the 3rd Floor Supply Closet had storage (paper/plastic cups) stacked in front of the wall mounted sprinkler head not allowing it to provide coverage to the supply room. Based on interview at the time of observation, the Facilities Operations Manager acknowledged the aforementioned sprinkler head was obstructed. This finding was acknowledged by the Facilities Operations Manager and Assistant Maintenance Supervisor at the time of observation and again at the exit conference on 08/03/22 at 12:50 p.m. 3.1-19(b)		deficient practice does not recur. The Maintenance Department will do weekly checks and maintain a log to stay in compliance with the code. In addition, the Facility Operations manager will report to the Quarterly QAPI committee meeting overseen by Mother Superior and the Administrator, Completion date 9/3/2022	

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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 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			

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	Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. 1. Based on observation and interview, the facility failed to ensure 3 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 8 staff and 10 residents. Findings include: Based on observations and interview during a tour of the facility with the Facilities Operations Manager and Assistant Maintenance Supervisor on 08/02/22 between 1:15 p.m. and 4:15 p.m. and again on 08/03/22 between 9:30 a.m. and 12:30 p.m., the following corridor doors failed to close and latch positively into the door frames: A) The 2nd Floor Scale room near Resident Room 218 B) The 2nd Floor East Laundry Room C) The 3rd Floor East Dining Room double doors D) The Shower/Restroom near Resident Room 354 Based on interview at the time of the observations, the Facilities Operations Manager agreed the aforementioned corridor door did not close and latch into the door frame and would not resist the passage of smoke. This finding was acknowledged by the Facilities Operations Manager and Assistant Maintenance Supervisor at the time of observation and again at the exit conference on 08/03/22 at 12:50 p.m. 2. Based on observation and interview, the facility failed to ensure 3 of over 30 corridor doors would	K 0363	**K 363 Corridor- Doors** What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice: Areas affected: The 2nd floor Scale room near Resident room 218, the 2nd floor East laundry,3rd floor east dining room doors double doors ,and the shower/restroom near Resident room 354. At this time The Little Sister of the Poor would like to request a temporary waiver for 6 months as there are supply chain shortages and logistic problems for our venders to get parts to repair and to bring up to code. Additionally, this are very expensive repairs, and the Home will be closing the 3rd floor permanently within the next 6 months. Completion date is 02/03/2023 The ½ inch hole above and below the door knob at the 2nd floor EAST hall /sisters storage room will be repaired with fire rated caulk. Further, the two ½-inch trough the chapel door will be repaired with fire caulk. Completion date is 09/03/2022 What measures will you put in to place and what systemic changes will be made to ensure that the deficient practice does not recur. The maintenance department will check doors monthly and maintain	02/03/2023

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	resist the passage of smoke. This deficient practice could affect 12 residents. Findings include: Based on observations and interview during a tour of the facility with the Facilities Operations Manager and Assistant Maintenance Supervisor on 08/02/22 between 1:15 p.m. and 4:15 p.m. and again on 08/03/22 between 9:30 a.m. and 12:30 p.m., the following corridor doors had holes which penetrated completely through the door: A) A 1/2-inch hole above and below the knob on the Sisters Storage on 2nd Floor West Hall. B) Two ½ inch holes through the Chapel door. This finding was acknowledged by the Facilities Operations Manager and Assistant Maintenance Supervisor at the time of observation and again at the exit conference on 08/03/22 at 12:50 p.m. 3.1-19(b)		a log to insure compliance with the code. Additionally, the Facility Operations Manager will report to the Quarterly QAPI committee meeting overseen by Mother superior and the Administrator. Completion date 9/3/2022 2. What are the reasonable completion dates for all deficiencies prior to the termination date per the waiver that is requested? For the Corridor Doors, the 6-month Temporary Waiver request documents an end date of 02/03/2023. The completion date is 02/03/2023. For the holes found in doors, the completion date is 09/08/2022. 3. What is the procedure for implementing actions that will prevent recurrence and how will it be monitored? The installation of the new doors will prevent future recurrence of the stated deficiency. For monitoring throughout the next six months until installation, the maintenance department will regularly monitor the doors and maintain a log to insure compliance with the code. 4. Who is responsible for implementation and monitoring of the plan for future compliance with regulations. The Facility Operations Manager is responsible for the implementation and monitoring for compliance. The Manager will	

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			report quarterly to the QAPI Committee.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 8 smoke barriers walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall	K 0372	K 372 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The maintenance department will seal the unsealed penetrations in the smoke barrier wall above the drop ceiling in the west hall dining area near the wooden double door set to stop the passage of smoke. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. The maintenance department will seal the unsealed smoke barrier wall above the drop ceiling in the	09/03/2022

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	be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 16 residents and staff on the West Hall Dining area. Findings include: Based on observations and interview during a tour of the facility with the Facilities Operations Manager and Assistant Maintenance Supervisor on 08/02/22 between 1:15 p.m. and 4:15 p.m. and again on 08/03/22 between 9:30 a.m. and 12:30 p.m., unsealed penetrations were discovered in the smoke barrier wall above the drop ceiling in the West Hall Dining area near the wooden double door set. This finding was acknowledged by the Facilities Operations Manager and Assistant Maintenance Supervisor at the time of observation and again at the exit conference on 08/03/22 at 12:50 p.m. 3.1-19(b)		west hall dining area near the wooden double doors stopping the passage of smoke, keeping the west area of the building safe for all the residents who travel through that part of the building. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does recur: The maintenance department will check the smoke barrier wall above the drop ceiling in the west hall dining area near the wooden double doors quarterly and main a log to insure compliance with the code . Additionally, the Facility Operations Manager will report to the Quarterly QAPI committee meeting overseen by Mother Superior and the Administrator. The completion date 9/3/2022	
K 0511 SS=F Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure all electrical panels in the corridors were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as	K 0511	**K 511 Utilities Gas and electric** What corrective action(s) will be accomplished for those residents found to be have been affected by the deficient practice: The maintenance department will	09/03/2022

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	specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect everyone. Findings include: Based on observations and interview during a tour of the facility with the Facilities Operations Manager and Assistant Maintenance Supervisor on 08/02/22 between 1:15 p.m. and 4:15 p.m. and again on 08/03/22 between 9:30 a.m. and 12:30 p.m., electrical panels on the 2nd and 3rd floors were unlocked when tested. The Assistant Maintenance Supervisor stated that it is an old building and the breakers in the corridor panels are how the corridor lights are tuned on and off at night. This finding was acknowledged by the Facilities Operations Manager and Assistant Maintenance Supervisor at the time of observation and again at the exit conference on 08/03/22 at 12:50 p.m. 2. Based on observation and interview, the facility failed to ensure 2 of over 10 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault		replace standard Electrical receptacle to a (GFCI) to have a ground-Fault circuit interrupter for the 3rd floor ice machine, and the 3rd floor washing machine in the third floor west laundry room .Further, the electrical panel boxes on 2nd and 3rd floors are now locked. How other residents having a potential to be affected by the deficient practice will be identified and what corrective action(s) will be taken. Replacing the electrical receptacles to (GFCI) receptacles and assuring electrical boxes are locked will protect all residents for a electrical hazard while in that area. What measures will be put in to place and what systemic changes will be made to ensure that the deficient practice does not recur. The maintenance Department will check (GFCI) electrical receptacles with a receptacle tester and check electrical boxes to assure they stay locked. Maintenance staff will maintain a monthly log. Additionally, the Facility Operations Manager will report to the Quarterly QAPI committee meeting overseen by Mother Superior and the Administrator. Completion date 9/3/2022	

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	Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical			

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	care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff and up to 4 residents 2 staff. Findings include: Based on observations and interview during a tour of the facility with the Facilities Operations Manager and Assistant Maintenance Supervisor on 08/02/22 between 1:15 p.m. and 4:15 p.m. and again on 08/03/22 between 9:30 a.m. and 12:30 p.m., the ice machine in (1) Second Floor East was connected to an electric receptacle which was being used to power the freestanding ice machine, with its own water supply. The ice machine was located within 3 feet of the electric receptacle, and not provided with ground fault circuit interruption (GFCI). And (2) the washing machine in the Third Floor West Laundry room was plugged into a receptacle behind the appliance which was not GFCI protected. This finding was acknowledged by the Maintenance Director at the time of observation and This finding was acknowledged by the Facilities Operations Manager and Assistant			

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	Maintenance Supervisor at the time of observation and again at the exit conference on 08/03/22 at 12:50 p.m. 3.1-19(b)			
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 Based on observation and interview, the facility failed to ensure 1 of 1 Chapel room was maintained in accordance with 19.7.5.6. LSC 19.7.5.6 prohibits combustible decorations unless an exception was met. This deficient practice could affect 20 residents and staff. Findings include: Based on observations and interview during a tour of the facility with the Facilities Operations Manager and Assistant Maintenance Supervisor on 08/02/22 between 1:15 p.m. and 4:15 p.m. and again on 08/03/22 between 9:30 a.m. and 12:30	K 0753	**K 753 Combustible Decorations** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A lit candle holds religious significance for the Home, the Sisters and the residents. The chapel has an operating sprinkler system. All candles are snuffed by the Sister responsible for the chapel or her designee at the end of religious services. No flammable candles are lit when the chapel is	09/03/2022

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	p.m., the chapel contained two wick burning candles near the front of the chapel. The Facilities Operations Manager stated that candles are generally found and hard to eliminate completely in the facility. This finding was acknowledged by the Facilities Operations Manager and Assistant Maintenance Supervisor at the time of observation and again at the exit conference on 08/03/22 at 12:50 p.m. 3.1-19(b)		unattended. A 24-hours battery operated candle stays ON day and night located at the left side of the tabernacle. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(S) will be taken. A lit candle holds religious significance for the Home, the Sisters and the residents. The chapel has an operating sprinkler system. All candles are snuffed by the Sister responsible for the chapel or her designee at the end of religious services. No flammable candles are lit when the chapel is unattended. A 24-hours battery operated candle stays ON day and night located at the left side of the tabernacle. What measures will be put in to place and what systemic changes will be made to ensure that the deficient practice does not recur. The Maintenance will check the chapel during daily rounds to insure we stay in compliance with the code. The Facility Operations Manager will report to the Quarterly QAPI committee meeting overseen by Mother Superior and the Administrator. Completion date 9/3/2022	
K 0920 SS=E	NFPA 101 Electrical Equipment - Power Cords and			

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	155825	A. BUILDING 01 B. WING	08/03/2022

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Bldg. 01	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 completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure power strips met UL rating of 1363A or 60601-1. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice affects 15 resident. Findings include:	K 0920	K 920 Electrical Equipment –Power cords. What corrective action(S) will be accomplished for those residents found to have been affected by the deficient practice: Power cords in resident rooms 309,246,248,315,302 and the salon will be removed and replaced with a 1363A labeled power strip. How other residents having the	09/03/2022

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	Based on observations and interview during a tour of the facility with the Facilities Operations Manager and Assistant Maintenance Supervisor on 08/02/22 between 1:15 p.m. and 4:15 p.m. and again on 08/03/22 between 9:30 a.m. and 12:30 p.m., the following was observed: A) Therapy Gym was using a power strip that lacked a UL rating of 1363A or 60601-1 label on the power strip. B) Resident Room 248 was using a power strip that lacked a UL rating of 1363A or 60601-1 label on the power strip. C) Resident Room 315 was using a power strip that lacked a UL rating of 1363A or 60601-1 label on the power strip. D) Resident Room 302 was using a power strip that lacked a UL rating of 1363A or 60601-1 label on the power strip and it was dangling from the wall. This finding was acknowledged by the Facilities Operations Manager and Assistant Maintenance Supervisor at the time of observation and again at the exit conference on 08/03/22 at 12:50 p.m. 2. Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 3 residents on the Salon. Findings include: Based on observations and interview during a tour of the facility with the Facilities Operations		potential to be affected by the same deficient practice will be identified and what corrective active action(s) will be taken. We will remove deficient power strips and replace with 1363A power strips, giving the residents a hazard free environment . 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 department will check resident areas for 1363a power strips quarterly and maintain a log to keep in compliance with the code . Additionally, the Facility Operations Manager will report to the Quarterly QAPI committee meeting overseen by Mother Superior and the Administrator. Completion date 9/3/2022.	

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	Manager and Assistant Maintenance Supervisor on 08/02/22 between 1:15 p.m. and 4:15 p.m. and again on 08/03/22 between 9:30 a.m. and 12:30 p.m., in the salon a power strip was being used to power a hairdryer and curling irons (high power draw equipment). This finding was acknowledged by the Facilities Operations Manager and Assistant Maintenance Supervisor at the time of observation and again at the exit conference on 08/03/22 at 12:50 p.m. 3. Based on observation and interview, the facility failed to ensure power cord daisy chains were not used as and as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. Article 400.8 (1) prohibits daisy chains, because the first extension cord (or power strip) is now acting as a substitute for the fixed wiring of a structure. This deficient practice could affect up to 4 residents in one smoke compartment. Findings include: Based on observations and interview during a tour of the facility with the Facilities Operations Manager and Assistant Maintenance Supervisor on 08/02/22 between 1:15 p.m. and 4:15 p.m. and again on 08/03/22 between 9:30 a.m. and 12:30 p.m., in Resident Room 309 two power strips were connected together being used to power Christmas lights. This finding was acknowledged by the Facilities Operations Manager and Assistant Maintenance Supervisor at the time of observation and again at the exit conference on 08/03/22 at 12:50 p.m.			

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	4. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords power strips powering medical equipment met the required UL rating of 1363A or 60601-1. This deficient practice affects one resident in room 246. Findings include: Based on observations and interview during a tour of the facility with the Facilities Operations Manager and Assistant Maintenance Supervisor on 08/02/22 between 1:15 p.m. and 4:15 p.m. and again on 08/03/22 between 9:30 a.m. and 12:30 p.m., an oxygen concentrator was plugged in to a power strip along with non-medical equipment that did not meet 1363A or 60601-1. This finding was acknowledged by the Facilities Operations Manager and Assistant Maintenance Supervisor at the time of observation and again at the exit conference on 08/03/22 at 12:50 p.m. 3.1-19(b)			
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)			

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	Based on observation and interview, the facility failed to ensure 1 of 3 oxygen storage rooms where oxygen transferring takes place, was provided with properly working mechanical ventilation. NFPA 99 2012 edition, 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical exhaust to maintain a negative pressure in the space continuously. This deficient practice could affect up to 15 residents. Findings include: Based on observations and interview during a tour of the facility with the Facilities Operations Manager and Assistant Maintenance Supervisor on 08/02/22 between 1:15 p.m. and 4:15 p.m. and again on 08/03/22 between 9:30 a.m. and 12:30 p.m., the storage/transfer room located on the 2nd floor east hallway contained large liquid oxygen tanks. The vent in the room did not contain a working mechanically ventilated exhaust fan with ventilated to the outside. Based on interview at the time of observation, the Facilities Operations Manager stated the oxygen room vent did not appear to be working and he was unsure if it vented to the outside. This finding was acknowledged by the Facilities Operations Manager and Assistant Maintenance Supervisor at the time of observation and again at the exit conference on 08/03/22 at 12:50 p.m. 3.1-19(b)	K 0927	K 927 Gas Equipment-Transfilling Cylinders . What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The maintenance department will repair or replace ventilation fan on 2nd east hallway to comply with the code. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. The maintenance department will repair or replace ventilation unit to maintain compliance with the code keeping all residents safe from hazards . 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 Department will verify that the ventilation unit is running quarterly and will maintain a log to insure we stay in compliance. Further, The Facility Operations Manager will report to the Quarterly QAPI committee meeting overseen by Mother Superior and the Administrator. Completion date 9/3/2022	09/03/2022