STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155678	A. BUILDING -- B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/29/24 Facility Number: 002667 Provider Number: 155678 AIM Number: 200300090 At this Emergency Preparedness survey, Waterford Place Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 103 and had a census of 80 at the time of this survey. Quality Review completed on 01/31/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/29/24 Facility Number: 002667 Provider Number: 1556787 AIM Number: 20030090 At this Life Safety Code survey, Waterford Place Health Campus was found not in compliance with Requirements for Participation in	K 0000	K0000 Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the position of Federal and State Law. The plan of correction is submitted in response to the allegation of noncompliance cited during survey	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rachel Bishir		02/15/2024

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	155678	A. BUILDING 01 B. WING	01/29/2024

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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type VIII construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and in the resident sleeping rooms. The facility has a capacity of 103 and had a census of 80 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 01/31/24		visit with exit on January 29, 2024. **The facility respectfully requests from the department a desk review for substantial compliance.**	
K 0131 SS=E 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 with Section 9.7.			

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	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 the penetration in 1 of 2 fire barrier walls that separated health care from assisted living was maintained to ensure the fire resistance of the barrier. 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 8.3.5.1 requires penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust 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 fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Fire Stops. This deficient practice could affect 10 residents in the service hall Findings include: Based on observation with the Facilities Management Support (FMS) on 01/29/24 at 3:15 p.m., in the attic above the separation fire barrier in the service hall, there was an unsealed three-inch hole in the wall. Based on interview at the time of observation, the FMS agreed the separation fire barrier had an unsealed hole through the wall. Maintenance sealed the hole at the time of discovery.	K 0131	K 131 Multiple Occupancies CFR(s): NFPA 101 Immediate Intervention: The DPO (Director of Plant Operations) sealed penetration before surveyor exited the campus. **(See photo of the repaired penetration attached.)** K 131 CFR(S) NFPA 101 The DPO (Director of Plant Operation) or designee, will audit fire walls in facility 1 X per week X 3 Months. **(See sample of audit attached).** The Director of Plant Operations was educated by the Executive Director and facility management support on LSC 8.3.5.1 requires penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust 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 fire barrier shall be protected by a firestop system or device. **(See copy of the education attached.)** The results of these audits will be presented by the Executive Director to the QA committee for further recommendations and	02/28/2024

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	The finding was reviewed with the Executive Director and FMS during the exit conference. 3.1-19(b)		continue until the Quality Assurance Team determines substantial compliance has been achieved.	
K 0222 SS=D Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 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			

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	systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised 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 1 of 8 delayed egress locks was readily accessible for all residents, staff, and visitors. LSC 7.2.1.6.1.(3)(4) states a readily visible, durable sign in letters not less than 1 in. (25mm) high and not less than 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM	K 0222	K 222 Egress Door's CFR(s) NFPA 101 Immediate Intervention: The Director of Plant Operations installed signage of not less than 1 inch high and not less than 1/8 inch in stroke width on a contrasting background that reads "Push until alarm sounds. Door can be opened in 15 seconds".	02/28/2024

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	SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect 5 residents exiting by the generator. Findings include: Based on observations during tour of the facility with the Facilities Management Support (FMS) on 01/29/24 at 2:30 p.m., the exit located in generator was provided with delayed egress locks but lacked the proper signage indicating the door can be opened in 15 seconds by pushing on the door. Based on interview at the time of observation, the FMS acknowledged the door was equipped with a delayed egress and lacked the proper signage. Maintenance installed this proper signage at the time of discovery. This finding was reviewed with the Executive Director and FMS at the exit conference. 3.1-19(b)		**(See photo of the signage installed attached).** The Director of Plant Operations was educated by the Executive Director on K222 NFPA 101 Egress Doors. LSC 7.2.1.6.1.(3) (4) states a readily visible, durable sign in letters not less than 1 in. high and not less than 1/8 in. in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: “PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS”. **(See copy of the education attached.)** The Director of Plant Operations will inspect the deficient delayed egress signage 1x week for 1 month and then 1 x month for 3 months. (**See copy of the audit(s) attached.)** The results of these audits will be presented by the Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire			

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	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 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 the corridor doors to 1 of 10 rooms which is a hazardous area containing combustible storage and greater than 50 square feet was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could 5 residents in the corridor by supply room 201.	K 0321	K 321 Hazardous Areas – Enclosure CFR(s) NFPA 101 **Immediate Intervention**: The DPO (Director of Plant Operations) replaced the door hinge that wasn't allowing the door to close and latch properly. **(See attached photo of the repair.)**	02/28/2024

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	Findings include: Based on observations during a tour of the facility with the Facilities Management Support (FMS) on 01/29/24 at 02:40 p.m., the door to supply room 201, a hazardous area, was equipped with a self-closing device but did not latch into the frame when tested. Based on interview at the time of observation, the FMS agreed that when tested, the supply room, which was a hazardous area, with a self-closing device on the door, did not latch into the frame. Maintenance repaired the door to allow it to latch properly at the time of discovery. This finding was reviewed with the Executive Director and FMS at the exit conference. 3.1-19(b)		The Director of Plant Operations was Educated by the Executive Director on NFPA 101 – Hazardous – Areas – Enclosed. A storage room of combustible supplies over 50 square feet in size, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. **(See attached copy of the education.)** The Director of Plant Operations will audit the door located in the kitchen for proper operation of the self-closing device and for proper latching into the frame 1 X per week X 8 weeks. **(See attached copy of the audit tool.)** Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2,			

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	19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen fire suppression system was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices. Hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect staff in the kitchen and 20 residents in the dining room. Findings include: Based on records review with the Facilities Management Support (FMS) on 01/29/24 at 01:15 p.m., the only documentation of semiannual kitchen fire suppression system inspection available for review was dated 01/03/24. Documentation of an inspection six months before 01/03/24 was not available for review. Based on	K 0324	K324 Cooking Facilities CFR(s) NFPA 101 Immediate Intervention: The DPO (Director of Plant Operations) scheduled Koorsen Fire and Security to have a semiannual kitchen suppression system inspection for June. (**See attached copy of the documentation from Koorsen showing the requested inspection).** The DPO (Director of Plant Operations) was educated by the Executive Director on the NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states 'Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, Hood exhaust plenums,	02/28/2024

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	interview at the time of record review, the FMS agreed the semiannual kitchen fire suppression system inspection documentation six months before the 01/03/24 inspection was not available. This finding was reviewed with the Executive Director and FMS at the exit conference. 3.1-19(b)		and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect staff in the kitchen and 20 residents in the dining non-management Support on (Cooking Facilities) (**See attached copy of the education)**. The DPO (Director of Plant Operations) or designee will audit semiannual inspections 2 x every 6 months. **(See attached copy of the audit).** The results of the audits will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	
K 0351 SS=D 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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	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 maintain the ceiling construction in 1 of 8 smoke compartments in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff and up to 5 residents in one smoke compartment. Findings include: Based on observations during a tour of the facility with the Facilities Management Support (FMS) on 01/29/24 at 2:40 p.m., in the lift storage room there was a missing sprinkler head escutcheon that allowed the hole around the sprinkler to be uncovered. Based on interview at the time of observation, the FMS agreed the aforementioned area was missing an escutcheon. Maintenance replaced the missing escutcheon at the time of discovery. This finding was reviewed with the Executive Director and FMS at the exit conference. 3.1-19(b)	K 0351	K 351 Sprinkler System-Installation CFR(s) NFPA 101 Immediate Intervention: The DPO (Director of Plant Operations) replaced the missing Escutcheon ring. **(See attached photo of the repair.)** The director of plant operations was educated by regional support on NFPA 101 Sprinkler installation as regards to maintaining the ceiling construction of sprinkler installation in accordance with NFPA 13 2010 edition, Section 6.2.7.1 **(See attached copy of the education).** The director of plant operations will visually inspect sprinkler escutcheons for proper placement weekly x 12 weeks and monthly x 3. **(See attached copy of the audit.)** The Executive Director will present the results of visual inspection through the QAPI committee for further recommendations and will continue until QAPI team determines substantial	02/28/2024

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			compliance has been achieved.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 2 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure	K 0353	K353 – Sprinkler System-Maintenance and testing. Immediate Intervention The DPO (Director of Plant Operations) has scheduled all quarterly inspections for 2024 with Koorsen Fire and Security. (See attached copy of the documentation from Koorsen showing the requested inspection.) The Executive Director has educated the Director of Plant Operations on Sprinkler System – Maintenace and testing automatic sprinkler and standpipe systems	02/28/2024

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	155678	A. BUILDING 01 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the quarterly sprinkler system inspection records with the Facilities Management Support (FMS) on 01/29/24 at 02:00 p.m., there were no quarterly sprinkler system inspection reports available for the first and third quarter of 2023. During an interview at the time of record review, the FMS acknowledged there was a sprinkler itemized valve report available, but no written documentation available to show the sprinkler system had been inspected during the first and third quarter of 2023. These findings were reviewed with the Executive Director and FMS at the exit conference. 3.1-19(b)		are inspected, tested and maintained in accordance with NFPA 25. The Director of Plant Operations will audit all inspection documents for completion 1 X per month X 6 months. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.			

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	18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to inspect 2 of over 20 portable fire extinguishers each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push to-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect 10 residents.	K 0355	K 355 Fire Extinguishers CFR(s) NFPA 101 Immediate Intervention: The DPO (Director of Plant Operations) rounded the facility checked and corrected the documentation for the monthly inspection tag on the Fire Extinguishers located in the Kitchen “K” Class and in the hall near Laundry. **(See attached photo of the inspection tag correction.)** The Director of Plant Operations was educated by the Executive Director on K 355 NFPA 101 Portable Fire Extinguishers. Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, standard for portable fire extinguishers 18.3.5.12, 19.3.5.12, NFPA 10 **(See attached copy of the education).** The Director of Plant Operations will audit fire extinguisher inspections 1 x week for 1 month and 1 x a month for 3 months. **(See attached copy of the audit.)** The Executive Director will present the results of visual inspection through the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	02/28/2024

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	Findings include: Based on observation during a tour of the facility with the Facilities Management Support (FMS) on 01/29/24 between 02:20 and 02:35 p.m., the monthly inspection tag on the K class fire extinguisher located in the kitchen and the fire extinguisher in the hall by laundry lacked documentation of a monthly inspection for November and December of 2023. Based on interview at the time of observation, the FMS confirmed the fire extinguishers located in the kitchen and by laundry lacked the monthly inspections previously mentioned. These findings were reviewed with the Executive Director and FMS at the exit conference. 3.1-19(b)			
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			

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	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 ensure only hold open devices that release when the door is pushed or pulled was used for 1 of 10 corridor doors. This deficient practice could affect 6 residents in the Dialysis room. Findings include: Based on observation with the Facilities Management Support (FMS) on 01/29/24 at 03:00 p.m., the door from the Dialysis treatment room to the break room was held open with a wedge under the door, and the door, with a self closer, would not close by just pulling or pushing the door. Based on interview at the time of observation, the FMS agreed a wedge was holding the door open	K 0363	K363 Corridor-Doors CFR(s) NFPA 101 Immediate Intervention: The DPO (Director of Plant Operations) removed the door stop immediately. (**See attached photo of the removed door stop).** The Director of Plant Operations was educated by the Executive Director on K363. There is no impediment to the closing of the doors. **(See attached copy of the education).** The Director of Plant Operations will audit the Dialysis Break Room for wedges that could prop door	02/28/2024

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	and could not close the door unless the wedge was removed. This finding was reviewed with the Executive Director and the FMS during the exit conference. 3.1-19(b)		open 1 X per week X 4weeks X 1 months. **(See attached copy of the audit).** Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	