STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155525	A. BUILDING -- B. WING	10/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SHADY NOOK CARE CENTER	36 VALLEY DR LAWRENCEBURG, IN 47025

(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: 10/11/23 Facility Number: 000304 Provider Number: 155525 AIM Number: 100266810 At this Life Safety Code survey, Shady Nook Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 94 certified beds. At the time of the survey, the census was 83. Quality Review completed on 10/16/23	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: 10/11/23 Facility Number: 000304 Provider Number: 155525 AIM Number: 100266810 At this Life Safety Code survey, Shady Nook Care Center was found not in compliance with	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lindsey Boltz	Administrator	11/02/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155525	A. BUILDING 01 B. WING	10/11/2023

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	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. This one story facility with a partial basement was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 94 and had a census of 83 at the time of this survey. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 10/16/23			
K 0161 SS=E Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories			

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	sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. Based on record review, observation and interview; the facility failed to maintain the building construction type for Type V(111) construction in 4 of 6 fire walls. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on review of facility floor plan documentation with the Administrator and the Maintenance Director during record review from 8:45 a.m. to 12:10 p.m. on 10/11/23, 2-hour fire resistance rated fire walls are located at the entrance to the A Street wing, the B Street wing, the C Street wing and the D Street wing by Room 41. Based on observations with the Administrator	K 0161	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 11-02-23 for the Emergency Preparedness survey date 10/11/23 and for the Life and Safety recertification and state licensure survey conducted on	10/12/2023

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	and the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:10 p.m. on 10/11/23, the entrance doors to the A Street wing by Room 11 were each equipped with a 90-minute fire resistance rating label affixed to the hinge side of door. Each door in the fire door set was equipped with latching hardware and each door latched into the door frame when tested to close. Foam was used to firestop the attic fire barrier wall penetration for a white HVAC pipe which penetrated the attic fire barrier wall above the corridor door set to the A Street wing by Room 11. Based on interview at the time of the observations, the Maintenance Director stated the UL listing and/or fire resistance rating documentation for the foam used to firestop the attic fire barrier wall was not available for review. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		10/11/23. We respectfully request a paper review and will provide any additional information requested. ***K161*** It is the practice of this facility to ensure the building construction is maintained for Type V (111) construction for 6 of 6 fire walls. **The corrective action taken for those residents found to be affected by the deficient practice include:** It is the policy of this facility to ensure that the construction of the facility is maintained to meet regulation, ensuring that appropriate firestop is utilized in the attic fire barrier wall(s) and documentation is present with the required UL listing and/or fire resistance rating. No residents or staff were affected by this requirement not met. Area of concern to the wall above the corridor door set to the A street wing, by room 11, construction to be maintained to meet requirement. **Other Residents that have the potential to be affected have been identified by:** This deficit has the potential to affect over 20 residents, staff and visitors. All areas assessed in attic for penetration and appropriate use of appropriate firestop with required UL listing and/or fire resistance rating.	

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			Please see below measures implemented to prevent reoccurrence. **The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:** In-service completed with maintenance director and administrator. Review and policy initiated to ensure that when maintenance repair and/or vendors are servicing facility that maintenance director is following with or directly after to ensure that penetration in fire barriers hasn't occurred. If penetration is present, then maintenance director will ensure that fire stop, with appropriate fire resistance rating and documentation, is in place. This will be discussed as part of operational morning and afternoon meetings. **The corrective action taken to monitor performance to assure compliance through quality assurance:** A performance improvement tool has been initiated to ensure that fire walls have not been penetrated. In addition to daily rounds and monitoring for a minimum of 3 months or until substantial compliance is achieved. A Quality Assurance tool has been developed and implemented to monitor the compliance of fire barrier walls in	

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			accordance with regulations. The tool will be completed by the maintenance director or designee, weekly X 3 weeks, monthly X 3 months, then quarterly for 2 quarters. Any identified issues will immediately be addressed. The outcomes will be reviewed through the facility Quality Assurance program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee, if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee, if warranted, based on the outcome of the tools. **The date the systemic changes will be completed:** 10/12/2023	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.			

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

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	on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 8 exits were 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 20 residents, staff and visitors if needing to exit the facility from the lower level. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:10 p.m. on 10/11/23, the exit door set to the outside of the facility on the lower level was marked as a facility exit with an exit sign. Each door could be opened by entering a four digit code into a keypad at the exit door set but the code was not posted to release the doors to open. Residents with a clinical diagnosis requiring specialized security measures reside in the D Street wing. Based on interview at the time of the observations, the Maintenance Director stated the exit door set to the outside of the facility is for the lower level of the facility and also serves as the exit to the outside of the facility if using the C Street stairwell exit door on the upper level by Room 27. Based on interview at the time of the observations, the Administrator and the	K 0222	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 11-02-23 for the Emergency Preparedness survey date 10/11/23 and for the Life and Safety recertification and state licensure survey conducted on 10/11/23. We respectfully request a paper review and will provide any additional information requested. ***K222*** It is the practice of this facility to ensure that all egress doors are readily accessible for residents, without a clinical diagnosis requiring specialized security measures, and staff. **The corrective action taken for those residents found to be affected by the deficient practice include:** It is the policy of this facility to	10/12/2023

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	Maintenance Director agreed the code to release the exit door set to the outside of the facility on the lower level was not posted at the exit door set. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		ensure that egress doors, marked as facility exit with exit signs, have the 4- digit code present with complete visibility to utilize egress doors. No residents or staff were affected. The exit door set to the outside of the facility exit, with an exit sign, has the 4-digit door code visibly present. 8 of 8 egress doors meet requirement. **Other Residents that have the potential to be affected have been identified by:** This deficit has the potential to affect over 20 residents, staff and visitors if needing to exit the facility from the lower level. All egress doors were reviewed and assessed to ensure in accordance to meet compliance. Please see below measures implemented to prevent reoccurrence. **The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:** In-service completed with maintenance director and administrator. Review initiated to ensure that doors with a required means of egress shall maintain compliance and meet regulation. This will be discussed as part of operational morning and afternoon meetings. **The corrective action taken to monitor performance to assure compliance through quality assurance:**	

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			A performance improvement tool has been initiated to ensure that egress doors meet compliance with 4-digit door codes visibly present. In addition to daily rounds and monitoring for a minimum of 3 months or until substantial compliance is achieved. A Quality Assurance tool has been developed and implemented to monitor the compliance of egress doors in accordance with regulations. The tool will be completed by the maintenance director or designee, weekly X 3 weeks, monthly X 3 months, then quarterly for 2 quarters. Any identified issues will immediately be addressed. The outcomes will be reviewed through the facility Quality Assurance program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee, if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee, if warranted, based on the outcome of the tools. **The date the systemic changes will be completed:** 10/12/2023	
K 0291 SS=D Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in			

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	accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 1 of 13 battery powered emergency lighting systems was maintained in accordance with LSC Section 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70, National Electric Code. This deficient practice could affect over 2 staff and visitors in the kitchen. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:10 p.m. on 10/11/23, the battery operated lighting system affixed to the wall above the glass window to the dining room failed to illuminate when its respective test button was pushed multiple times. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned battery powered emergency lighting system failed to illuminate when its respective test button was pushed multiple times. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0291	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 11-02-23 for the Emergency Preparedness survey date 10/11/23 and for the Life and Safety recertification and state licensure survey conducted on 10/11/23. We respectfully request a paper review and will provide any additional information requested. ***K291*** It is the practice of this facility to ensure that all battery powered emergency lighting systems are maintained in accordance with LSC Section 7.9, ensuring that they will illuminate. **The corrective action taken for those residents found to be affected by the deficient practice include:** It is the policy of this facility to ensure that all battery-operated lighting systems are maintained and have reliable types of rechargeable batteries with	10/12/2023

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			suitable facilities for maintaining them in properly charged conditions. The emergency battery-operated lighting system affixed to the wall above the glass window to the dining room has reliable, rechargeable batteries and illuminates when the respective test button is pushed. 13 of 13 battery powered emergency lighting systems meet requirement. **Other Residents that have the potential to be affected have been identified by:** This deficit has the potential to affect 2 staff and visitors in the kitchen. All emergency battery operated lighting systems were reviewed and assessed to ensure in accordance to meet compliance. Please see below measures implemented to prevent reoccurrence. **The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:** In-service completed with maintenance director and administrator. Review initiated to ensure that battery operated emergency lighting shall maintain compliance and meet regulations. This will be discussed as part of operational morning and afternoon meetings. **The corrective action taken to monitor performance to assure**	

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			compliance through quality assurance: A performance improvement tool has been initiated to ensure that 13/13 of battery-operated emergency lighting systems meet compliance with reliable, rechargeable batteries to ensure illumination. In addition to daily rounds and monitoring for a minimum of 3 months or until substantial compliance is achieved. A Quality Assurance tool has been developed and implemented to monitor the compliance of egress doors in accordance with regulations. The tool will be completed by the maintenance director or designee, weekly X 3 weeks, monthly X 3 months, then quarterly for 2 quarters. Any identified issues will immediately be addressed. The outcomes will be reviewed through the facility Quality Assurance program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee, if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee, if warranted, based on the outcome of the tools. **The date the systemic changes will be completed:** 10/12/2023	

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K 0321 SS=D 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 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 1 of over 13 hazardous areas such as fuel fired heater rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic	K 0321	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or	10/12/2023

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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
	closing in accordance with 7.2.1.8. This deficient practice could affect over 2 staff and visitors on the lower level. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:10 p.m. on 10/11/23, the annular space surrounding a two inch in diameter pipe which penetrated the ceiling above the water softener in the Mechanical Room on the lower level was not firestopped. Two natural gas fired boilers were installed in the room. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned opening in the Mechanical Room ceiling did not separate this hazardous area from other spaces with smoke resistant partitions. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 11-02-23 for the Emergency Preparedness survey date 10/11/23 and for the Life and Safety recertification and state licensure survey conducted on 10/11/23. We respectfully request a paper review and will provide any additional information requested. ***K321*** It is the practice of this facility to ensure that fuel, fired heater rooms are separated from other spaces by smoke resistant partitions and/or doors. That no penetrations are present for 13 of 13 of the noted hazardous areas. **The corrective action taken for those residents found to be affected by the deficient practice include:** It is the policy of this facility to ensure that all hazardous areas are separated from other spaces by smoke resistant partitions. The annular space surrounding a two inch in diameter pipe which penetrated the ceiling above the water softener, in the Mechanical room, on the lower level is repaired with drywall and appropriate fire-resistant rated firestop in	

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			place. 13 of 13 hazardous areas are separated from other spaces, by smoke resistant partitions and meet requirement. **Other Residents that have the potential to be affected have been identified by:** This deficit has the potential to affect 2 staff members and visitors on the lower level. All hazardous areas, such as fuel, fired, heater rooms were reviewed and assessed to ensure in accordance to meet compliance. Please see below measures implemented to prevent reoccurrence. **The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:** In-service completed with maintenance director and administrator. Review initiated to ensure that all hazardous areas shall maintain compliance and meet regulations. This will be discussed as part of operational morning and afternoon meetings. **The corrective action taken to monitor performance to assure compliance through quality assurance:** A performance improvement tool has been initiated to ensure that 13/13 hazardous areas are separated from other spaces by smoke resistant partitions or doors. In addition to daily rounds and monitoring for a minimum of 3	

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			months or until substantial compliance is achieved. A Quality Assurance tool has been developed and implemented to monitor the compliance of 13/13 hazardous areas in accordance with regulations. The tool will be completed by the maintenance director or designee, weekly X 3 weeks, monthly X 3 months, then quarterly for 2 quarters. Any identified issues will immediately be addressed. The outcomes will be reviewed through the facility Quality Assurance program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee, if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee, if warranted, based on the outcome of the tools. **The date the systemic changes will be completed:** 10/12/2023	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.			

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	9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. Based on observation and interview, the facility failed to maintain the fire alarm system to ensure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:10 p.m. on 10/11/23, the remote fire alarm control panel located near the entrance to the D Street wing read the time of day as 12:03 p.m. at 12:45 p.m. The main fire alarm control panel in the sprinkler riser room read the time of day as 12:24 p.m. at 1:07 p.m. Based on interview at the time of the observations, the Maintenance Director agreed the fire alarm system did not display the accurate time of day. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to ensure all fire alarm system initiating devices were inspected and tested in accordance with the schedules for inspection and testing frequencies in NFPA 72. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, Table 14.3.1 at 9(h) states	K 0345	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 11-02-23 for the Emergency Preparedness survey date 10/11/23 and for the Life and Safety recertification and state licensure survey conducted on 10/11/23. We respectfully request a paper review and will provide any additional information requested. ***K345*** It is the practice of this facility to maintain the fire alarm system and ensure that the accurate time and date information is in accordance with requirements. **The corrective action taken for those residents found to be affected by the deficient practice include:** It is the policy of this facility to ensure that all fire alarm systems are maintained and have the accurate time and date present on the fire alarm system. The remote fire alarm control panel located near the entrance to the D street	11/02/2023

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	smoke detectors shall be visually inspected semiannually. NFPA 72, 2010 Edition, Table 14.4.5 at 15(h) states smoke detectors shall be functionally tested annually. NFPA 72, Table 14.3.1 at 9(f) states heat detectors shall be visually inspected semiannually. NFPA 72, Section 14.4.5 states heat detector testing shall be performed in accordance with the schedules in Table 14.4.5. Initial/Reacceptance testing shall be performed at the time of installation. Table 14.4.5 at 15(e) states the requirements of 14.4.5.5 shall apply to heat detectors. Section 14.4.5.5 states restorable fixed-temperature, spot-type heat detectors shall be tested in accordance with 14.4.5.5.1 through 14.4.5.5.4. Two or more detectors shall be tested on each initiating circuit annually. Different detectors shall be tested each year. NFPA 72, 2010 Edition, Table 14.4.2.2 at 14(d)(2) states fixed-temperature, nonrestorable line type heat detectors functionality shall be tested mechanically and electrically. Loop resistance shall be measured and recorded. Changes from acceptance test shall be investigated. Records shall be kept by the building owner specifying which detectors have been tested. Within 5 years, each detector shall have been tested. This deficient practice could affect over two staff. Findings include: Based on review of the fire alarm system inspection contractor's "Smoke and Duct Detectors" section and "Heat & Carbon Monoxide Detectors" section of the "Fire Alarm System Inspection" report dated 02/09/23 with the Administrator and the Maintenance Director during record review from 8:45 a.m. to 12:10 p.m. on 10/11/23, no smoke detectors or heat detectors in the elevator machine room were listed as being inspected or tested within the most recent twelve		wing and the main fire alarm control panel in the sprinkler room reflect the accurate time and date. All fire alarm systems reflect the accurate date and time to meet requirement. **Other Residents that have the potential to be affected have been identified by:** This deficit has the potential to affect all residents, staff, and visitors. All fire alarm systems are reviewed and assessed to ensure in accordance to meet compliance. Please see below measures implemented to prevent reoccurrence. **The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:** In-service completed with maintenance director and administrator. Review initiated to ensure that all fire alarm systems shall maintain compliance and meet regulations. This will be discussed as part of operational morning and afternoon meetings. **The corrective action taken to monitor performance to assure compliance through quality assurance:** A performance improvement tool has been initiated to ensure that all fire alarm systems meet compliance in maintaining accurate date and time. In addition to daily rounds and monitoring for	

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	month period. Based on interview at the time of record review, the Maintenance Director stated additional fire alarm testing documentation for the most recent twelve month period was not available for review and stated the facility has one elevator machine room. Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:10 p.m. on 10/11/23, a heat detector was installed in the basement elevator machine room. Based on interview at the time of record review and of the observations, the Maintenance Director agreed it could not be ensured fire alarm system testing documentation included elevator machine room initiating device inspection and testing within the most recent twelve month period. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		a minimum of 3 months or until substantial compliance is achieved. A Quality Assurance tool has been developed and implemented to monitor the compliance of fire alarm systems, in accordance with regulations. The tool will be completed by the maintenance director or designee, weekly X 3 weeks, monthly X 3 months, then quarterly for 2 quarters. Any identified issues will immediately be addressed. The outcomes will be reviewed through the facility Quality Assurance program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee, if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee, if warranted, based on the outcome of the tools. **The date the systemic changes will be completed:** 11/02/2023 By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 11-02-23 for the Emergency	

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			Preparedness survey date 10/11/23 and for the Life and Safety recertification and state licensure survey conducted on 10/11/23. We respectfully request a paper review and will provide any additional information requested. ***K345*** It is the practice of this facility to ensure that all fire alarm system initiating devices are inspected and tested in accordance with the schedules for inspection and testing frequencies and to ensure that record keeping is present specifying which have been tested. **The corrective action taken for those residents found to be affected by the deficient practice include:** It is the policy of this facility to ensure that all fire alarm system initiating devices are inspected and tested in accordance with the schedules for inspection and testing frequencies for the facility. It is the policy of the facility to ensure that record keeping is present specifying what has been tested. Record reflects and ensures that fire alarm system testing documentation includes the elevator machine room initiating device inspection and testing within the most recent twelve-month period. All fire alarm system initiating devices are	

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			inspected in accordance with the schedules for inspection and testing frequencies, record keeping is present to reflect to ensure compliance. **Other Residents that have the potential to be affected have been identified by:** This deficit has the potential to affect over two staff. All fire alarm system initiating devices are reviewed and assessed, including record keeping ensuring in accordance to meet compliance. Please see below measures implemented to prevent reoccurrence. **The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:** In-service completed with maintenance director and administrator. Review initiated with maintenance director and Safecare, to ensure that all fire alarm system initiating devices are inspected and added, as warranted, to testing frequency and scheduling to maintain compliance and meet regulations. This will be discussed as part of operational morning and afternoon meetings. **The corrective action taken to monitor performance to assure compliance through quality assurance:** A performance improvement tool	

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			has been initiated to ensure that all fire alarm system initiating devices are inspected with testing frequencies to meet compliance. The facility conducted, with maintenance director and Safecare, the initial inspection of initiating devices located in the facility and the scheduling frequency audit. A quality assurance tool has been developed and implemented for the maintenance director, or designee, to audit Safecares inspection of the fire alarm system initiating devices record quarterly X 4 quarters, ensuring proper inspection and record keeping of all devices. The compliance audit will continue until substantial compliance is achieved, in accordance with regulations. Any identified issues will immediately be addressed. The outcomes will be reviewed through the facility Quality Assurance program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee, if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee, if warranted, based on the outcome of the tools. **The date the systemic changes will be completed:** 11/02/2023	

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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) 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 8.6.3.4, "Minimum Distance between Sprinklers", states sprinklers shall be spaced not less than 6 feet on center. In addition, LSC 4.6.7.5 requires existing life safety features that do not meet the requirements for new buildings, but exceed the requirements for existing buildings shall not be further diminished. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the oxygen storage room for the facility.	K 0351	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 11-02-23 for the Emergency Preparedness survey date 10/11/23 and for the Life and Safety recertification and state	11/02/2023

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	Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:10 p.m. on 10/11/23, two separate ceiling mounted sprinklers are installed four and one half feet from one another in the oxygen storage room by the elevator. One of the sprinklers is installed near the center of the room and the second sprinkler is installed near one of the four walls. 108 'E' type oxygen cylinders were stored in the room. Based on interview at the time of the observations, the Maintenance Director agreed the two ceiling mounted sprinklers were spaced less than 6 feet apart. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the deflectors for 1 of 2 ceiling mounted sprinklers in the oxygen storage room for the facility were installed parallel to the slope of the ceiling. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition, Section 8.5.4.2 states deflectors of sprinklers shall be aligned parallel to ceilings, roofs, or the incline of stairs. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the oxygen storage room for the facility. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the		licensure survey conducted on 10/11/23. We respectfully request a paper review and will provide any additional information requested. ***K351*** It is the practice of this facility to ensure that the minimum distance between sprinklers is maintained, ensuring that they are spaced not less than 6 feet on the center. **The corrective action taken for those residents found to be affected by the deficient practice include:** It is the policy of this facility to ensure that all sprinklers meet the required minimum distance between sprinklers. One of the two separate ceiling mounted sprinklers that are installed four-and one-half feet from one another in the oxygen storage room by the elevator, has a current work order in place for Safecare to remove the additional sprinkler not required. All sprinklers meet the required minimum distance between sprinklers throughout the facility. **Other Residents that have the potential to be affected have been identified by:** This deficit has the potential to affect over 10 residents, staff, and visitors in the vicinity of the oxygen storage room for the facility. All sprinklers are reviewed and assessed to ensure in accordance to meet compliance.	

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	facility from 12:10 p.m. to 2:10 p.m. on 10/11/23, the deflector for the ceiling mounted sprinkler nearest the wall was not installed parallel to the ceiling in the oxygen storage room for the facility. Based on interview at the time of the observations, the Maintenance Director agreed the ceiling mounted sprinkler nearest the wall in the oxygen storage room was not properly installed. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 D Street shower rooms 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 over 10 residents, staff, and visitors in the vicinity of the D Street shower room. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:10 p.m. on 10/11/23, the ceiling mounted sprinkler in the closet of the D Street shower room by Room 41 was missing its escutcheon which exposed the attic above. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned sprinkler location was missing its escutcheon. These findings were reviewed with the		Please see below measures implemented to prevent reoccurrence. **The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:** In-service completed with maintenance director and administrator. Review initiated to ensure that all sprinklers maintain compliance and meet regulations. This will be discussed as part of operational morning and afternoon meetings. **The corrective action taken to monitor performance to assure compliance through quality assurance:** A performance improvement tool has been initiated to ensure that all sprinklers meet compliance for minimum distance between sprinklers. A Quality Assurance tool has been developed and implemented to monitor the compliance of all sprinklers, meeting minimum distance in accordance with regulations. The tool will be completed by the maintenance director or designee, annually. Any identified issues will immediately be addressed. The outcomes will be reviewed through the facility Quality Assurance program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee, if needed to obtain 100%	

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	Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		compliance. Additional action will be taken by the Quality Assurance Committee, if warranted, based on the outcome of the tools. **The date the systemic changes will be completed:** 11/02/2023 By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 11-02-23 for the Emergency Preparedness survey date 10/11/23 and for the Life and Safety recertification and state licensure survey conducted on 10/11/23. We respectfully request a paper review and will provide any additional information requested. ***K351*** It is the practice of this facility to ensure the escutcheon is present for all mounted sprinklers in the facility. **The corrective action taken for those residents found to be affected by the deficient practice include:** It is the policy of this facility to	

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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
			ensure that all mounted sprinklers have escutcheon in place. The ceiling mounted sprinkler in the closet of the D street shower room by room 41 has escutcheon in place. All escutcheons for mounted sprinklers meet the requirement for proper installation. **Other Residents that have the potential to be affected have been identified by:** This deficit has the potential to affect over 10 residents, staff, and visitors in the vicinity of the D street shower room. All sprinklers are reviewed and assessed to ensure in accordance to meet compliance. Please see below measures implemented to prevent reoccurrence. **The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:** In-service completed with maintenance director and administrator. Review initiated to ensure that all mounted sprinklers are properly installed, with escutcheon in place, to maintain compliance and meet regulations. This will be discussed as part of operational morning and afternoon meetings. **The corrective action taken to monitor performance to assure compliance through quality assurance:** A performance improvement tool	

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			has been initiated to ensure that all sprinklers meet compliance for properly installed mounted sprinklers, with escutcheon(s) in place. A Quality Assurance tool has been developed and implemented to monitor the compliance of all mounted sprinklers to ensure escutcheon(s) are in place. The tool will be completed by the maintenance director or designee, weekly X 3 weeks, monthly X 3 months, then quarterly for 2 quarters. Any identified issues will immediately be addressed. The outcomes will be reviewed through the facility Quality Assurance program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee, if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee, if warranted, based on the outcome of the tools. **The date the systemic changes will be completed:** 11/02/2023 By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of	

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			correction be considered our allegation of compliance effective 11-02-23 for the Emergency Preparedness survey date 10/11/23 and for the Life and Safety recertification and state licensure survey conducted on 10/11/23. We respectfully request a paper review and will provide any additional information requested. ***K351*** It is the practice of this facility to ensure that all mounted sprinklers are installed parallel to the ceiling, roofs or incline of stairs. **The corrective action taken for those residents found to be affected by the deficient practice include:** It is the policy of this facility to ensure that all mounted sprinklers are installed properly. The ceiling mounted sprinkler nearest the wall in the oxygen storage room has current work order to be removed, as it also does meet the minimum distance and an additional sprinkler is not needed. All mounted sprinklers were reviewed to ensure they meet the requirement for proper installation. **Other Residents that have the potential to be affected have been identified by:** This deficit has the potential to affect over 10 residents, staff, and visitors in the vicinity of the oxygen storage room for the	

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			facility. All mounted sprinklers are reviewed and assessed to ensure in accordance to meet compliance. Please see below measures implemented to prevent reoccurrence. **The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:** In-service completed with maintenance director and administrator. Review initiated to ensure that all mounted sprinklers are properly installed to maintain compliance and meet regulations. This will be discussed as part of operational morning and afternoon meetings. **The corrective action taken to monitor performance to assure compliance through quality assurance:** A performance improvement tool has been initiated to ensure that all mounted sprinklers meet compliance for proper installment. A Quality Assurance tool has been developed and implemented to monitor the compliance of all mounted sprinklers to ensure they remain properly installed. The tool will be completed by the maintenance director or designee, weekly X 3 weeks, monthly X 3 months, then quarterly for 2 quarters. Any identified issues will immediately be addressed. The outcomes will be reviewed through	

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			the facility Quality Assurance program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee, if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee, if warranted, based on the outcome of the tools. **The date the systemic changes will be completed:** 11/02/2023	
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 maintain automatic sprinkler systems in	K 0353	By submitting the enclosed material, we are not admitting the	11/02/2023

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	accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 5.3.1.1.1.6 states dry sprinklers that have been in service for 10 years shall be replaced or representative samples shall be tested and then retested at 10-year intervals. NFPA 25, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. 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. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the sprinkler system inspection contractor's "Work Acknowledgement" documentation dated 11/07/19 with the Administrator and the Maintenance Director during record review from 8:45 a.m. to 12:10 p.m. on 10/11/23, four dry pendent sprinklers were sent out for testing and were replaced with new sprinklers on 11/07/19. Documentation of the results of sprinkler testing on or after 11/07/19 was not available for review. Based on interview at the time of record review, the Administrator and the Maintenance Director tried to obtain documentation from the sprinkler inspection contractor but stated the contractor's company was subsequently sold and agreed		truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 11-02-23 for the Emergency Preparedness survey date 10/11/23 and for the Life and Safety recertification and state licensure survey conducted on 10/11/23. We respectfully request a paper review and will provide any additional information requested. ***K353*** It is the practice of this facility to ensure that automatic sprinklers are inspected, tested and maintained per regulation and record keeping is present. **The corrective action taken for those residents found to be affected by the deficient practice include:** It is the policy of this facility to ensure that automatic sprinklers are inspected, tested and maintained in accordance with regulation and proper record keeping is present. The form, titled “Work Acknowledgement” showed the four dry pendent sprinklers were sent out but no further documentation could be retrieved	

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	documentation of the results of sprinkler testing on or after 11/07/19 was not available for review. Based on interview at the time of record review, the Administrator and the Maintenance Director stated they were not aware if any additional sprinkler testing or replacement by a different contractor was conducted on or after 11/07/19. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		with documentation regarding the results of this testing. Safecare work order is in place to ensure testing is completed and record is kept at facility. **Other Residents that have the potential to be affected have been identified by:** This deficit has the potential to affect all staff, all residents and all visitors. Safecare work order in place to ensure compliance is met. Please see below measures implemented to prevent reoccurrence. **The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:** In-service completed with maintenance director and administrator. Initially effort was towards locating documentation of completed service but the contracted business, no longer in business, was unable to provide this documentation. Once unable to locate, an immediate work order was placed to ensure proper inspection, testing and maintaining of water-based fire protection is in place with proper record keeping. **The corrective action taken to monitor performance to assure compliance through quality assurance:** Once the Safecare work order is completed, the record will be	

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			maintained. Inspection, testing, and maintaining of water-based fire protection systems will be completed to meet compliance for this regulation, ensuring 100% compliance with testing requirements. Additional action will be taken by the Quality Assurance Committee, if warranted. **The date the systemic changes will be completed:** 11/02/2023	
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			

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	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 3 of 47 corridor doors to resident sleeping rooms would resist the passage of smoke. This deficient practice could affect over 40 residents, staff and visitors. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:10 p.m. on 10/11/23, the corridor door to resident sleeping Room 24 and Room 26 each latched into the door frame when tested to close but a one and a half inch gap was noted in between the face of the door and the door stop on the door frame near the top of the door. The corridor door to Room 33 latched into the door frame when tested to close but a one inch gap was noted in between the face of the door and the door stop on the door frame near the top of the door. Based on interview at the time of	K 0363	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 11-02-23 for the Emergency Preparedness survey date 10/11/23 and for the Life and Safety recertification and state licensure survey conducted on 10/11/23. We respectfully request a paper review and will provide any additional information requested.	10/16/2023

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	the observations, the Maintenance Director agreed the aforementioned three corridor doors would not resist the passage of smoke when the doors were in the fully closed and latched position. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		***K363*** It is the practice of this facility to ensure that doors resist the passage of smoke, ensuring there is no impediment to the closure of the doors. **The corrective action taken for those residents found to be affected by the deficient practice include:** It is the policy of this facility to ensure that all corridor doors to resident sleeping rooms resist the passage of smoke. 3 of the 47 corridor doors show no impediment to closure and prevention of the passage of smoke. All corridor doors were reviewed to ensure they meet the requirement to prevent the passage of smoke. **Other Residents that have the potential to be affected have been identified by:** This deficit has the potential to affect over 40 residents, staff, and visitors. All corridor doors were reviewed and assessed to ensure in accordance to meet compliance. Please see below measures implemented to prevent reoccurrence. **The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:** In-service completed with maintenance director and	

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			administrator. Review initiated to ensure that all corridor doors show no impediment to closing and preventing the passage of smoke to maintain compliance and meet regulations. This will be discussed as part of operational morning and afternoon meetings. **The corrective action taken to monitor performance to assure compliance through quality assurance:** A performance improvement tool has been initiated to ensure that all corridor doors meet compliance for prevention of the passage of smoke. A Quality Assurance tool has been developed and implemented to monitor the compliance of all corridor doors to ensure they remain able to close preventing the passage of smoke. The tool will be completed by the maintenance director or designee, weekly X 3 weeks, monthly X 3 months, then quarterly for 2 quarters. Any identified issues will immediately be addressed. The outcomes will be reviewed through the facility Quality Assurance program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee, if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee, if warranted, based on the outcome of the tools.	

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			The date the systemic changes will be completed: 10/16/2023	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on observation and interview, the facility failed to ensure egress corridors were not used as a portion of a return air system serving adjoining rooms for 47 of 47 resident rooms. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, Section 4.3.12.1.1 states egress corridors in nursing and long term care facilities shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas unless otherwise permitted by 4.3.12.1.3.1 through 4.3.12.1.3.4. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:10 p.m. on 10/11/23, all forty seven resident rooms were using the egress corridor as a return air system. Based on interview at the time of the observations, the Maintenance Director and the facility Administrator confirmed the forty seven resident rooms were using the egress corridor as a return	K 0521	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 10-16-23 to the Recertification and State Licensure Survey completed on September 19, 20, 21, 22, 25 2023. We respectfully request a paper review and will provide any additional information requested. ***K521*** /p> The facility has been granted a waiver for K021 each year since 1990, when the tag was first cited. Following the 1990 survey, the facility had installed a system whereby the activation of the fire alarm, including the automatic	11/02/2023

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	air system. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		sprinkler system and the automatic smoke detection would shut down the supply air fans. In 1990, the facility obtained an estimate from a contractor to install return air ducts in each resident's room. The cost at that time was approximately $29,782.00. All fire protection devices are tested by Safe Care on an annual basis. Sprinkler system tested by Safe Care quarterly. Facility maintenance conducts fire drills quarterly on shifts (1) and (2) when alarm is tripped.	
K 0531 SS=D Bldg. 01	NFPA 101 Elevators Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI			

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	A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 Based on record review, observation and interview; the facility failed to ensure 1 of 1 elevators were equipped with shunt trip devices for 1 of 1 sprinklered machine rooms. NFPA 13, Standard for the Installation of Sprinkler Systems, Section 8.15.5.3 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon, or prior to, the application of water from the sprinkler located in the elevator machine room. NFPA 101, Section 9.7.3.1 states in any occupancy where the character of the fuel for fire is such that extinguishment or control of fire is accomplished by a type of automatic extinguishing system in lieu of an automatic sprinkler system, such system shall be installed in accordance with the appropriate standard as determined in accordance with Table 9.7.3.1. If the extinguishing system is installed in lieu of a required, supervised automatic sprinkler system, the activation of the extinguishing system shall activate the building fire alarm system, where provided. The actuation of an extinguishing	K 0531	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 11-02-23 for the Emergency Preparedness survey date 10/11/23 and for the Life and Safety recertification and state licensure survey conducted on 10/11/23. We respectfully request a paper review and will provide any additional information requested. ***K531*** It is the practice of this facility to ensure that the elevator is equipped with a shunt trip device	11/02/2023

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SHADY NOOK CARE CENTER	36 VALLEY DR LAWRENCEBURG, IN 47025

(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
	system that is not installed in lieu of a required, supervised automatic sprinkler system shall be indicated at the building fire alarm system, where provided. This deficient practice could affect over two staff and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Smoke and Duct Detectors" section and "Heat & Carbon Monoxide Detectors" section of the "Fire Alarm System Inspection" report dated 02/09/23 with the Administrator and the Maintenance Director during record review from 8:45 a.m. to 12:10 p.m. on 10/11/23, no smoke detectors or heat detectors in the elevator machine room were listed as being inspected or tested within the most recent twelve month period. Based on interview at the time of record review, the Maintenance Director stated additional fire alarm testing documentation for the most recent twelve month period was not available for review and stated the facility has one elevator machine room. Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:10 p.m. on 10/11/23, the elevator machine room in the basement is sprinklered. A shunt trip device could not be located. Based on interview at the time of the observations, the Maintenance Director stated a heat detector was installed in the basement elevator machine room but did not know the location of an elevator shunt trip device. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		for sprinklered machine rooms. **The corrective action taken for those residents found to be affected by the deficient practice include:** It is the policy of this facility to ensure that that the elevator is equipped with a shunt trip device and is identifiable by the facility. It is the policy of the facility to ensure that all heat detectors are inspected, and that the inspection is kept on record for review. The elevator shunt trip device location is able to be identified and the heat detector located in the elevator room is inspected to meet compliance. **Other Residents that have the potential to be affected have been identified by:** This deficit has the potential to affect over 2 staff and visitors. The shunt trip device location is able to be identified and all heat detectors are inspected, with appropriate documentation present, to ensure in accordance to meet compliance. Please see below measures implemented to prevent reoccurrence. **The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:** In-service completed with maintenance director and administrator. Review initiated to ensure that the elevator shunt trip	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155525	A. BUILDING 01 B. WING	10/11/2023

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			device is able to be identified, and that all heat detectors are inspected with appropriate documentation. **The corrective action taken to monitor performance to assure compliance through quality assurance:** A performance improvement tool has been initiated to ensure that all heat detectors are inspected to meet compliance. The tool will be completed by the maintenance director or designee, annually to ensure inspection has been completed for all heat detectors and that the facility maintains required documentation. Any identified issues will immediately be addressed. The outcomes will be reviewed through the facility Quality Assurance program. Monitoring will continue or will be increased by the Quality Assurance Committee, if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee, if warranted, based on the outcome of the tools. **The date the systemic changes will be completed:** 11/02/2023	