STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155798	A. BUILDING -- B. WING	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASHTON CREEK HEALTH AND REHABILITATION CENTER	4111 PARK PLACE DRIVE FORT WAYNE, IN 46845

(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: 07/19/23 Facility Number: 012861 Provider Number: 155798 AIM Number: 201080610 At this Emergency Preparedness survey, Ashton Creek Health and Rehabilitation Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 139 and had a census of 111 at the time of this survey. Quality Review completed on 07/24/23	E 0000	This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitue admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed soley because it is required by the provisions of the federal and state law. We respectfully request paper complaince for this plan of correction.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility]			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Molly Linder	Administrator	08/07/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155798	A. BUILDING -- B. WING	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASHTON CREEK HEALTH AND REHABILITATION CENTER	4111 PARK PLACE DRIVE FORT WAYNE, IN 46845

(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
	must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient	E 0004	Corrective action for affected residents: 1. A meeting was held with	08/04/2023

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	practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 07/19/23 at 10:41 a.m., no documentation could be found to show the EPP was reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director stated the EEP has not been reviewed or updated within the last year. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		management team to discuss and review the EPP and any needed updates. How other residents have potential to be affected: 2. All residents have the potential to be affected by the alleged deficient practice. Measures put into place and systematic changes: 3. The management staff review for the EPP will be scheduled for March of every year moving forward. How the corrective action will be monitored: 4. Results of the March review of the EPP will be forwarded to the Quality Assurance Committee for review. Date Systemic changes will be completed: Systemic changes for deficiency will be completed by 8/4/23	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b),			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155798	A. BUILDING -- B. WING	07/19/2023

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	§441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must			

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	155798	A. BUILDING -- B. WING	07/19/2023

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	address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.			
	Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Policies and Procedures were reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 07/19/23 at 10:41 a.m., no documentation could be found to show the EPP Policies and Procedures were reviewed and updated within the last year. Based on an interview during records review, the Maintenance	E 0013	Corrective action for affected residents: 1. A meeting was held with management team to discuss and review the EPP and any needed updates. How other residents have potential to be affected: 2. All residents have the potential to be affected by the alleged deficient practice.	08/04/2023

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	Director stated the EEP Policies and Procedures has not been reviewed or updated within the last year. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		Measures put into place and systematic changes: 3. The management staff review for the EPP will be scheduled for March of every year moving forward. How the corrective action will be monitored: 4. Results of the March review of the EPP will be forwarded to the Quality Assurance Committee for review. Date Systemic changes will be completed: Systemic changes for deficiency will be completed by 8/4/23	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC			

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	facilities]. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Communication program was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 07/19/23 at 10:41 a.m., no documentation could be found to show the EPP Communication program was reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director stated the EEP Communication program has not been reviewed or updated within the last year. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0029	Corrective action for affected residents: 1. A meeting was held with management team to discuss and review the EPP and any needed updates. How other residents have potential to be affected: 2. All residents have the potential to be affected by the alleged deficient practice. Measures put into place and systematic changes: 3. The management staff review for the EPP will be scheduled for March of every year moving forward. How the corrective action will be monitored: 4. Results of the March review of the EPP will be forwarded to the Quality Assurance Committee for review. Date Systemic changes will be completed: Systemic changes for deficiency will be completed by 8/4/23	08/04/2023
E 0036 SS=F	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d),			

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Bldg. --	484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program			

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	must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.			
	Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Training and Testing program was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include:	E 0036	Corrective action for affected residents: 1. A meeting was held with management team to discuss and review the EPP and any needed updates. How other residents have potential	08/04/2023

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	Based on records review with the Administrator and Maintenance Director on 07/19/23 at 10:41 a.m., no documentation could be found to show the EPP Training and Testing program was reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director stated the EEP Training and Testing program has not been reviewed or updated within the last year. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		to be affected: 2. All residents have the potential to be affected by the alleged deficient practice. Measures put into place and systematic changes: 3. The management staff review for the EPP will be scheduled for March of every year moving forward. How the corrective action will be monitored: 4. Results of the March review of the EPP will be forwarded to the Quality Assurance Committee for review. Date Systemic changes will be completed: Systemic changes for deficiency will be completed by 8/4/23	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/19/23 Facility Number: 012861 Provider Number: 155798	K 0000	This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitue admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The	

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	AIM Number: 201080610 At this Life Safety Code survey, Ashton Creek Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 139 and had a census of 111 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 07/24/23		plan of correction is prepared and/or executed soley because it is required by the provisions of the federal and state law. We respectfully request paper complaince for this plan of correction.	
K 0223 SS=E Bldg. 01	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a			

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	required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure 1 of 2 laundry doors to a hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2. This deficient practice could affect staff in the service hall. Findings include: Based on observation during a tour of the facility with Maintenance Director on 07/19/23 at 9:30 a.m., the laundry room contained fuel fired equipment making this a hazardous area. The clean side door was self-closing, but the door was propped open from the front. Based on interview at the time of observation, the Maintenance Director agreed the door was held open with a device that did not release with the fire alarm. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)	K 0223	Corrective action for affected residents: 1. Items propping the laundry door were removed and door was immediately closed. How other residents have the potential to be affected: 2. This deficient practice could affect in the service hall. Measure put into place and systematic changes: 3. An audit will be completed daily for 6 weeks, 3 times a week for 3 weeks and weekly until 100% compliant. How the corrective action will be monitored: 4. Results of this audit will be forwarded to the Quality Committee for review monthly for 6 months with a goal of 100% compliance. Once 100% compliance is achieved frequency of further review will be determined by the QAPI committee. Date systemic Changes will be completed:	08/04/2023

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			Systemic changes for deficiency will be complete by 8/4/23	
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, 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 observation and interview, the facility failed to maintain 2 of 4 kitchen corridor doors to ensure cooking facilities that serve 30 or more residents were not open to the corridor. This deficient practice affects 50 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 07/19/23 at 12:00 p.m., the main kitchen, which serve 30 or more residents, was	K 0324	orrective action for affected residents: 1. Cart that was blocking the kitchen door was removed and door was immediately closed. How other residents have the potential to be affected: 2. Up to 50 residents in 1 smoke compartment have the potential to	08/04/2023

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	155798	A. BUILDING 01 B. WING	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASHTON CREEK HEALTH AND REHABILITATION CENTER	4111 PARK PLACE DRIVE FORT WAYNE, IN 46845

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	open to the corridor due to two of the kitchen corridor doors were blocked from closing due to a cart in front of the doors. Based on interview at the time of the observations, the Maintenance Director agreed the doors were blocked from closing and did remove the cart. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		be affected by the alleged deficient practice. Measure put into place and systematic changes: 3. An audit will be completed daily for 6 weeks, 3 times a week for 3 weeks and weekly until 100% compliant. How the corrective action will be monitored: 4. Results of this audit will be forwarded to the Quality Committee for review monthly for 6 months with a goal of 100% compliance. Once 100% compliance is achieved frequency of further review will be determined by the QAPI committee. Date systemic Changes will be completed: Systemic changes for deficiency will be complete by 8/4/23	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.			

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	a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 6 of 6 sprinkler heads in the carport were not loaded and covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff and up to 25 residents that use the front entrance. Findings include: Based on observation with the Maintenance Director on 07/19/23 at 12:29 p.m., all the sprinkler heads in the carport outside of the main entrance was loaded with dirt. Based on interview at the time of observation, the Maintenance Director confirmed the sprinkler heads in the carport were loaded with dirt. The finding was reviewed with the Administrator and Maintenance Director during the exit	K 0353	Corrective action for affected residents: 1. The spider webs were cleaned off of the sprinklers. Ceilings were power washed and sprinklers are in good working order. How other residents have the potential to be affected: 2. Up to 25 residents and staff that use the front entrance the potential to be affected by the alleged deficient practice. Measuress put into place and systematic changes: 3. An audit will be completed weekly until 100% compliant . How the corrective action will be monitored: 4. Results of this audit will be forwarded to the Quality Assurance Committee for review monthly for 6 months with a goalwith 100% compliance. One	08/04/2023

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	conference. 3.1-19(b)		100% compliance is achieved frequency of further review will be determined by the QAPI committee. Date systemic changes will be completed: 5. Systemic changes for deficiency will be completed by 8/4/23	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover			

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	devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation, records review, and interview, the facility failed to enforce 1 of 1 non-smoking policies. This deficient practice could affect staff that use the employee entrance/exit and door #6. Findings include: Upon arrival to the facility on 07/19/23 at 9:00 a.m., two staff members were observed smoking by the employee entrance/exit. Based on observations with the Maintenance Director at 11:30 a.m., smoking on property was evident due cigarette butts on the ground outside exit #6. Based on records review at 10:00 a.m., the smoking policy stated, "Tobacco use is prohibited throughout the campus." Based on interview at the time of observation and records review, the Maintenance Director stated the facility is a non-smoking campus and confirmed there was smoking on property by staff. The findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0741	Corrective action for affected residents: 1. All cigarette butts were immediately picked up. How other residents have the potential to be affected: 2. This deficient practice could affect staff that use the employee entrance/exit and door #6. Measures put into place and systematic changes: 3. All staff have received education on the non-smoking policy. An audit will be completed daily for 6 weeks, 3 times a week for 3 weeks and weekly until 100% compliant. How the corrective action will be monitored: 4. Results of this audit will be forwarded to the Quality Assurance Committee for review monthly for 6 months with a goalof 100% compliance. Once 100% compliance is achieved frequency of further review will be determined by the QAPI committee. Date systemic changes will be	08/04/2023

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			completed: 5. Systemic changes for deficiency will be completed by 8/4/23	