STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155384	A. BUILDING -- B. WING	05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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: 05/13/2024 Facility Number: 000411 Provider Number: 155384 AIM Number: 100275100 At this Emergency Preparedness survey, Brickyard Healthcare-Lincoln Hills 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 a capacity of 86 certified beds and had a census of 66 at the time of this visit. Quality Review completed on 05/20/24	E 0000	Preparation and submission of this Plan of Correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the facility has prepared and submits this Plan of Correction solely as a requirement under State and Federal Law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and 19 programs, and to provide the best possible care to our residents as possible.	
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: 05/13/2024 Facility Number: 000411 Provider Number: 155384 AIM Number: 100275100 At this Life Safety Code survey, Brickyard	K 0000	Preparation and submission of this Plan of Correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the facility has prepared and submits this Plan of Correction solely as a requirement under State and Federal Law that mandates a submission of a Plan	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Julie Pennington	Executive Director	06/18/2024

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	Healthcare-Lincoln Hills Care 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 with a lower level was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 86 and had a census of 66 at the time of this survey. All areas where the residents have customary access were sprinklered, except resident room closets, and all areas providing facility services were sprinklered except a metal shed containing facility storage. Quality Review completed on 05/20/24		of Correction as a condition to participate in Title 18 and 19 programs, and to provide the best possible care to our residents as possible.	
K 0100 SS=D Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 1 of 1 carbon monoxide detectors in the boiler room was properly maintained. NFPA 101 at 19.1.1.3.1 states all health care facilities shall	K 0100	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The carbon	06/13/2024

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	be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect staff in the boiler room. Findings include: Based on observation during a tour of the facility with the Director of Maintenance on 05/13/2024 between 1:00 PM and 5:45 PM, the carbon monoxide detector in the boiler room did not have batteries installed. The carbon monoxide detector did not appear to be hardwired and appeared to not be working due to lack of power. Based on interview at the time of observation, the Director of Maintenance agreed there were no batteries in the carbon monoxide detector. This finding was reviewed with the Director of Maintenance and the Executive Director. 3.1-19(b)		monoxide detector in the boiler room will have the batteries replaced. How will other residents having the potential to be affected by this same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Any resident in this area may be affected by this practice. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? Carbon monoxide detector inspections are completed monthly in the TELS system. How will the corrective action be monitored to ensure the deficient practice will not recur? The Maintenance Director will report findings no less than quarterly in perpetuity in the Quality Assurance Performance Improvement meeting.	
K 0200 SS=E Bldg. 01	NFPA 101 Means of Egress Requirements - Other Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life			

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	Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 Based on observation and interview, the facility failed to ensure 1 of 1 main floor dining closets was equipped with only 1 locking mechanism which was able to be unlocked from the inside in the case of fire or other emergencies in accordance with LSC 7.1.10.1. This deficient practice could affect staff. Findings include: Based on observation during a tour of the facility on 05/13/2024 between 1:00 PM and 5:45 PM with the Director of Maintenance, the main floor dining closet had a slide lock on the outside of the door and did not have a mechanism for opening the door form the inside. Based on interview at the time of observation, the Director of Maintenance agreed the door had a slide lock and was unable to be opened from the inside. This finding was reviewed with the Executive Director and the Director of Maintenance at the exit conference. 3.1-19(b)	K 0200	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The side lock on the main floor dining room closet has been removed. How will other residents having the potential to be affected by this same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Any resident in this area could be affected by this practice. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? Audits will be conducted 1x weekly for six months to ensure there is no side lock on the main floor dining room closet. How will the corrective action be monitored to ensure the deficient practice will not recur? The Maintenance Director will report finding of the audits in the monthly Quality Assurance Performance Improvement meeting for six months or until no further corrective action is needed.	06/13/2024

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K 0222 SS=D Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection 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			

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	Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 The facility failed to ensure the delayed egress locking arrangements were installed in accordance with 7.2.1.6.1(3) in 1 of 1 laundry hallways and 1 of 10 hallways. LSC 7.2.1.6.1(3) states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall	K 0222	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The irreversible process to release the lock will be repaired to release the lock on the egress doors in the #10 hallway and the laundry hallway. The laundry hallway egress code will be posted by the keypad and the 15 second egress sticker removed to allow free egress from the facility. How will other residents having the	06/13/2024

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	activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect residents, staff, and visitors within the facility. Findings include: Based on observations and interview during a tour of the facility on 05/13/2024 between 1:00 PM and 5:45 PM with the Director of Maintenance, when the 15 second delayed egress doors were pushed in the #10 hallway and the laundry hallway, the irreversible process to release the lock was not initiated. Based on interview at the time of observations, the Director of Maintenance agreed the doors identified with delayed egress signage would not open unless a code was entered into the keypad and that the company the facility contracts with had recently came in and worked on the doors. This finding was reviewed with the Executive Director and Director of Maintenance at the exit conference. 3.1-19(b)		potential to be affected by this same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Any resident in the area may be affected by this deficient practice. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? The test operation inspection of the doors and locks will be completed monthly in the TELS system. How will the corrective action be monitored to ensure the deficient practice will not recur? The Maintenance Director will report the findings no less than quarterly in perpetuity in the Quality Assurance Performance Improvement meeting.	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure all battery backup lights were tested monthly over the past year to ensure the	K 0291	What corrective action will be accomplished for those residents found to have been affected by the	06/13/2024

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	light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: During record review on 05/13/2024 between 9:00 AM and 1:00 PM with the Director of Maintenance, there was no documentation regarding monthly battery operated emergency light testing during May, June, July, August, September, and December of 2023. Based on interview at the time of record review, the Director of Maintenance was not aware of any additional documentation of the battery operated emergency lights testing anywhere else in the building. This finding was reviewed with the Director of Maintenance and the Executive Director at the exit conference. 3.1-19(b)		deficient practice. The Maintenance Director will maintain monthly testing of the battery backup lights with a record of visual inspections and tests. How will other residents having the potential to be affected by this same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Any resident in this area may be affected by this practice. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? A monthly 30 second functional test inspection of the Emergency Lighting will be completed in the TELS system. How will the corrective action be monitored to ensure the deficient practice will not recur? The Maintenance Director will report no less than quarterly in perpetuity the findings of the visual inspections and tests.	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the			

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	provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, interview and observation, the facility failed to ensure documentation for the preventative maintenance of all battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: During record review on 05/13/2024 between 9:00 AM and 1:00 PM with the Director of Maintenance, no documentation was available for review regarding battery operated smoke detector monthly testing for May, June, July, August, September, October, and November in 2023. Based on interview at the time of record review, the Director of Maintenance agreed there was no documentation of monthly battery operated smoke detector testing from the aforementioned months of 2023. Based on observations during a tour of the facility from 1:00 PM to 5:45 PM during a tour of the facility with the Director of Maintenance, battery operated smoke alarms were observed in all resident sleeping rooms.	K 0300	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Maintenance Director will maintain documentation of the preventative maintenance of all battery-operated smoke alarms in residents' rooms. How will other residents having the potential to be affected by this same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. All residents in this area have the potential to be affected by this practice. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? A monthly inspection will be completed in the TELS system of the battery-operated smoke alarms in the residents' rooms. How will the corrective action be monitored to ensure the deficient practice will not recur? The Maintenance Director will report no less than quarterly in perpetuity on	06/13/2024

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	This finding was reviewed with the Executive Director and the Director of Maintenance at the exit conference. 3.1-19(b)		the findings of the inspections of the battery-operated smoke alarms in residents' rooms in the Quality Assurance Performance Improvement meeting.	
K 0321 SS=F 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			

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	Hazard - see K322) Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 basement storage rooms near the hallway to the kitchen, 1 of 1 activities storage rooms near room 16, 1 of 1 storage rooms behind the dry storage, 1 of 1 medical waste rooms, 1 of 1 engineering rooms, 1 of 1 maintenance rooms, and 1 of 1 storage rooms near room 7 was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect all residents, staffs and visitors while in the vicinity of these rooms. Findings include: Based on observations during a tour of the facility on 05/13/2024 between 1:00 PM and 5:45 PM with the Director of Maintenance, the basement storage room near the hallway to the kitchen, the storage room behind the dry storage room, the medical waste room, the engineering room, the maintenance room, the activities storage room near room 16, and the storage rooms near room 7 were being used as storage for a significant amount of combustible items, including paper and cardboard and the rooms were not equipped with self-closing mechanisms. Each room appeared to be 50 square feet or more. Based on interview at the time of observation, the Director of Maintenance agreed there was a significant amount of storage and they would be removing the items. This finding was reviewed with the Executive Director and Director of Maintenance at the exit conference. 3.1-19(b)	K 0321	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The combustible material in the basement storage rooms and room 7 was removed. How will other residents having the potential to be affected by this same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Any residents in this area could be affected by this practice. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? A monthly inspection will be completed in the TELS system on Doors - Hazardous or over 50 square feet. How will the corrective action be monitored to ensure the deficient practice will not recur? The Maintenance Director will report the results of the inspection no less than quarterly in perpetuity in the Quality Assurance Performance Improvement meeting.	06/13/2024

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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 ensure the cook top for 1 of 1 stoves/ovens in the therapy room was shut off at the switch when not in use. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10)	K 0324	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The padlock was removed from the lock box and the cook top was turned off. How will other residents having the potential to be affected by this same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Any residents	06/13/2024

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	and (13) are met. 19.3.2.5.3(9) states A switch meeting all the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect residents, staff and visitors in the therapy room. Findings include: Based on observation during a tour of the facility on 05/13/2024 between 1:00 PM and 5:45 PM with the Director of Maintenance, there was a cooktop stove/oven in the therapy room. The stove/oven disconnect was located in a padlocked box above the oven/stove which was locked. The stove/oven display was flashing the time, indicating the stove/oven had power. At the time of observation, the stove/oven was not in use by residents or staff. Based on interview at the time of observation, the Director of Maintenance agreed the stove/oven shut off was located in a padlocked and locked box and the stove/oven had power. The Director of Maintenance asked his assistant to remove the lock and turn off the stove/oven. This finding was reviewed with the Executive Director and Director of Maintenance at the exit conference. 3.1-19(b)		in this area have the potential to be affected by this practice. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? Audits will be conducted 1x monthly for six months to ensure the power to the cook top is turned off. How will the corrective action be monitored to ensure the deficient practice will not recur? The Maintenance Director will report results of the audits in the monthly Quality Assurance Performance Improvement meeting for six months or until no further corrective action is needed.	
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance			

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	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. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time 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 observation of the fire alarm control panel on 05/13/2024 at 2:22 PM with the Director of Maintenance, the time on the fire alarm control panel was incorrect. The display on the fire alarm control panel indicated the time was 3:42 PM. Based on interview at the time of observation, the Director of Maintenance agreed the time being displayed was incorrect. This finding was reviewed with the Director of Maintenance and the Executive Director at the exit conference. 3.1-19(b)	K 0345	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The display on the fire alarm control panel has been repaired. How will other residents having the potential to be affected by this same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Any resident in this area has the potential to be affected by this practice. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? A monthly inspection will be completed in the TELS system to verify the fire alarm system, verify the time and the date on the fire alarm system. How will the corrective action be monitored to ensure the deficient	06/13/2024

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			practice will not recur? The Maintenance Director will report the results of the inspection no less than quarterly in perpetuity in the Quality Assurance Performance Improvement meeting.	
K 0351 SS=F 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 maintain the ceiling construction in 1 of 1 Central Supply B rooms, and 1 of 1 main floor dining 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	K 0351	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The sprinkler head in areas with mixed response were replaced with all quick response sprinkler heads and sprinkler issues were resolved	06/13/2024

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	be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff and all residents in the main floor dining room Findings include: Based on observations during a tour of the facility on 05/13/2024 between 1:00 PM and 5:45 PM with the Director of Maintenance, 2 of 3 escutcheons in Central Supply B and 1 of 10 escutcheons in the main floor dining room were missing from the sprinkler heads. Based on interview at the time of the observations, the Director of Maintenance agreed the escutcheons in the aforementioned locations were missing. This finding was reviewed with the Executive Director and Director of Maintenance at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure only one type of sprinkler head, i.e., quick response or standard sprinklers were installed in 1 of 7 smoke compartments. NFPA 13, 2010 Edition, Installation of Sprinkler Systems, Section 8.3.3.2 states where quick-response sprinklers are installed, all sprinklers within a compartment shall be quick-response unless otherwise permitted in Section 8.3.3.3 Section 8.3.3.4 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a compartmented space shall be changed. This deficient practice could affect at least 20 residents, staff, and visitors. Findings include: Based on observations during a tour of the facility		by Tri State Fire Protection. All residents in the area have the potential to be affected by this practice. How will other residents having the potential to be affected by this same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. All residents in this area have the potential to be affected by this practice. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? A monthly inspection of the Fire Sprinkler System, in house inspection, will be completed in the TELS system. How will the corrective action be monitored to ensure the deficient practice will not recur? The Maintenance Director will report the results of the inspection no less than quarterly in perpetuity in the Quality Assurance Performance Improvement meeting.	

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	on 05/13/2024 between 1:00 PM and 5:45 PM with the Director of Maintenance, the main entrance hallway and the business office was equipped with both quick response and standard response sprinklers. Based on interview at the time of the observations, the Director of Maintenance agreed there were both standard response and quick response sprinklers in the main entrance hallway and the business office. This finding was reviewed with the Executive Director and Director of Maintenance at the exit conference. 3.1-19(b)			
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 1. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 kitchen hallways, 1 of 1 dry storage rooms, 1 of 1	K 0353	What corrective action will be accomplished for those residents found to have been affected by the	06/13/2024

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	storage rooms behind dry storage room, 1 of 1 basement dining rooms, 1 of 1 central stairwells, 1 of 1 main floor storage rooms, 1 of 1 rooms near main floor storage room and oxygen room, 1 of 1 storage rooms by central supply, 1 of 1 bathrooms near room 67, 1 of 1 kitchenettes, 1 of 1 bathrooms near room 31, 1 of 1 MDS rooms, 1 of 1 hallway near room 18, 1 of 1 main floor dining closets, 1 of 1 main floor dining rooms, 1 of 1 social services offices, 1 of 1 main entrance hallways, 1 of 1 copier rooms, 1 of 1 soiled utility rooms by room 10, and 1 of 1 hallways near rooms 8 and 10. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations during a tour of the facility on 05/13/2024 between 1:00 PM and 5:45 PM with the Director of Maintenance, the following was observed: a. a penetration of 3 inches in the ceiling near the sprinkler head in the kitchen hallway just outside the kitchen b. a penetration of 4 inches in the ceiling in the dry storage room c. a cracked ceiling tile in the dry storage room d. a penetration of 1 foot by 3 inches in the ceiling in the storage room behind the dry storage room e. a 4 inch by 3 inch penetration in the ceiling near the coffee bar wall		deficient practice. The penetrations in the walls identified will be repaired. The sprinkler head near the therapy room will be repaired/replaced as needed. How will other residents having the potential to be affected by this same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Any resident in this area has the potential to be affected by this practice. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? A six-month inspection in the TELS system of the ceiling tile, hard ceiling penetration check, will be completed. How will the corrective action be monitored to ensure the deficient practice will not recur? The Maintenance Director will report the results of the inspection no less than quarterly in perpetuity in the Quality Assurance Performance Improvement meeting.	

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	f. a 2 inch penetration in the ceiling near the sprinkler head in the central stairwell g. a 1 inch penetration in ceiling in the main floor storage room near the oxygen room h. a 2 inch penetration in the ceiling in the main floor storage room near the oxygen room i. the room near the main floor storage room by the oxygen room was missing a ceiling tile j. a 1/2 inch penetration in the ceiling in the storage room near central supply k. a 1 inch penetration in the ceiling in the storage room near central supply l. a 1/2 inch penetration in ceiling of the bathroom near room 67 by the fan m. the kitchenette had a cord running from behind the mini fridge up through the ceiling tile and appeared to be the cause of the ceiling tile being tilted out of place n. a 1/4 inch penetration in the ceiling of the bathroom near room 31 o. a 2 inch penetration around 2 of 2 bathroom lights in the bathroom near room 31 p. a 2 inch penetration in the ceiling near the sprinkler head in the MDS room q. a 3 inch penetration in the ceiling of the dining room closet r. a 2 inch penetration in the ceiling of the dining room near the piano s. a 1 inch penetration around 1 of 3 sprinkler heads in the social services office t. a 2 inch penetration in the ceiling tile in the main hallway near the business hallway u. a 3 inch penetration in the ceiling in the copier room v. a 2 inch penetration in the ceiling in the soiled utility room near room 10 w. a 1 inch penetration in the ceiling in the room between rooms 8 and 10 Based on interview at the time of the observations, the Director of Maintenance agreed			

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	there were penetrations in the walls in the aforementioned locations and provided the measurements. This finding was reviewed with the Director of Maintenance and Executive Director at the exit conference. 3.1-19(b) 2. Based on interview and observation, the facility failed to ensure 1 of 1 sprinkler heads outside the therapy room covered with rust/corrosion were replaced. 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 any resident, staff, or visitor while in the area of the therapy room. Findings include: Based on observations during a tour of the facility on 05/13/2024 between 1:00 PM and 5:45 PM with the Director of Maintenance, 1 corroded sprinkler head was located in the hallway near the therapy room. Based on interview at the time of observation, the Director of Maintenance agreed the sprinkler head was corroded. This finding was reviewed with the Executive Director and the Director of Maintenance at the			

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	exit conference. 3.1-19(b)			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 1. Based on observation and interview, the facility failed to inspect 1 of 1 portable fire extinguishers in the beauty shop, 1 of 1 portable fire extinguishers in the boiler room, 1 of 1 portable fire extinguishers in the therapy room, 1 of 1 portable fire extinguishers in the main floor soiled utility rooms near room 25, and 1 of 1 portable fire extinguishers in the assistant administrator office each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using pushto-test pressure indicators. Section 7.2.4.1 states personnel making manual	K 0355	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Maintenance Director will complete inspections on the fire extinguishers in the beauty shop boiler room, therapy room, main floor soiled utility room and assistant administrator's office (Business Office). How will other residents having the potential to be affected by this same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. All residents in this area have the potential to be affected by this practice. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? A monthly inspection of the fire	06/13/2024

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	inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect residents, staff, and visitors in these areas. Findings include: Based on observation during a tour of the facility with the Director of Maintenance on 05/13/2024 between 1:00 PM and 5:45 PM, the monthly inspection tag on the fire extinguishers in the following locations indicated the following: a. the fire extinguisher in the beauty shop had not been signed that it was inspected in January, February, March, and April of 2024 b. the fire extinguisher in the boiler room had not been signed that it was inspected in April of 2024 c. the fire extinguisher in the therapy room had not been signed that it was inspected in January, February, March, and April of 2024 d. the fire extinguisher in the main floor soiled utility room near room 25 had not been signed that it was inspected in April 2024 e. the fire extinguisher in the assistant administrator office had a tag which indicated it was last inspected in September of 2023 Based on interview at the time of observations,		extinguishers will be completed in the TELS system. How will the corrective action be monitored to ensure the deficient practice will not recur? The Maintenance Director will report the results of the inspection no less than quarterly in perpetuity in the Quality Assurance Process Improvement meeting.	

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	the Director of Maintenance stated he was unaware of fire extinguishers in the aforementioned locations. This finding was reviewed with the Executive Director and Director of Maintenance at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers located in the assistant administrator's office was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect staff. Findings include: Based on an observation during a tour of the facility on 05/13/2024 between 1:00 PM and 5:45			

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	PM, the fire extinguisher in the assistant administrator's office had a tag which indicated the last annual inspection date was March 2023. Based on interview at the time of observation, the Director of Maintenance acknowledged the fire extinguisher in the assistant administrator's office was past due for the annual inspection. This finding was reviewed with the Executive Director and Director of Maintenance at the exit conference. 3.1-19(b)			
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are			

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	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 1 of 1 resident sleeping room doors to room 70 were able to latch in the door frame. This deficient practice could affect staff, visitors, and up to 2 residents. Findings include: Based on observation during a tour of the facility on 05/13/2024 between 1:00 PM and 5:45 PM with the Director of Maintenance, the door to room 70 was unable to latch into the door frame Based on interview at the time of observation, the Director of Maintenance agreed the door to room 70 was unable to latch into the frame. This finding was reviewed with the Executive Director and Director of Maintenance at the exit conference. 3.1-19(b)	K 0363	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The door to room 70 will be repaired to enable latching of the door to the frame. How will other residents having the potential to be affected by this same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. All residents with doors to their rooms have the potential to be affected by this practice. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur?	06/13/2024

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			An inspection of the doors, door latch check will be completed monthly in the TELS system. How will the corrective action be monitored to ensure the deficient practice will not recur? The Maintenance Director will report the results no less than quarterly in perpetuity in the Quality Assurance Performance Improvement meeting.	
K 0372 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations in the smoke barrier walls near the kitchen hallway, therapy room, room 63, and room 23 were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect all staff and residents.	K 0372	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The unsealed penetrations identified will be repaired. How will other residents having the potential to be affected by this same deficient practice be	06/13/2024

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	Findings include: Based on observations with the Director of Maintenance on 05/13/2024 between 1:00 PM and 5:45 PM the following unsealed penetrations were discovered: a. a 2 inch penetration in the smoke barrier wall near the kitchen hallway b. a 1/4 inch penetration in the smoke barrier wall near the therapy room c. a 1/2 inch penetration in the smoke barrier wall near the therapy room d. 2 2 inch penetrations in the smoke barrier wall near room 63 e. a 1 inch penetration in the smoke barrier wall near room 23 Based on interview at the time of observation, the Director of Maintenance agreed there were penetrations in the aforementioned locations and provided the measurements. This finding was reviewed with the Executive Director and the Director of Maintenance at the exit conference. 3.1-19(b)		identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Any residents in this area have the potential to be affected by this practice. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? An inspection of the smoke barriers and fire walls will be completed every six months in the TELS system. How will the corrective action be monitored to ensure the deficient practice will not recur? The Maintenance Director will report no less than quarterly in perpetuity the results of the inspections of the smoke barriers and fire walls in the Quality Assurance and Performance Improvement meeting.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors			

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	are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 1 sets of smoke barrier doors near the therapy room would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect some residents going to the therapy room, staff, and visitors while in the vicinity of the therapy room. Findings include: Based on observation during a tour of the facility with the Director of Maintenance on 05/13/2024 between 1:00 PM and 5:45 PM, the set of smoke barrier doors near the therapy room did not close completely. The smoke barrier doors were 1/2 inch from closing completely. Based on interview during the time of observation, the Director of Maintenance agreed the doors did not close completely. This finding was reviewed with the Executive Director and the Director of Maintenance at the exit conference. 3.1-19(b)	K 0374	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The smoke barrier doors near the therapy room will be repaired to close immediately. How will other residents having the potential to be affected by this same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Any residents in this area have the potential to be affected by this practice. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? An inspection of the smoke barrier doors and fire walls will be completed every six months in the TELS system. How will the corrective action be monitored to ensure the deficient practice will not recur? The Maintenance Director will report the results of the inspection no less than quarterly in perpetuity in	06/13/2024

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			the Quality Assurance Performance Improvement meeting.	
K 0500 SS=F Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 5 of 5 boilers had current inspection certificates to ensure the boilers were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review on 05/13/2024 between 9:00 AM and 1:00 PM with the Director of Maintenance, the following five boilers had expired or missing Certificate of Inspection documentation from the State of Indiana: a. the service boiler identified as IN0333304 had a Certificate of Inspection stating the expiration date was 05/12/2024. b. the service boiler identified as IN0337950 had a Certificate of Inspection stating the expiration date was 05/12/2024. c. the service boiler identified as IN0355341 had a Certificate of Inspection stating the expiration	K 0500	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The boiler inspections will be completed. How will other residents having the potential to be affected by this same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Any residents in this area have the potential to be affected by this practice. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? An inspection of the boiler water heaters, confirm state inspection, will be completed in the TELS system every 12 months.	06/13/2024

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	date was 05/12/2024. d. the service boiler identified as IN0355342 had a Certificate of Inspection stating the expiration date was 05/12/2024. e. the service boiler identified as IN0308090 had a Certificate of Inspection stating the expiration date was 05/12/2024. Based on interview at the time of record review, the Director of Maintenance stated there was no additional documentation regarding the Certificates of Inspection and agreed the Certificates of inspection were expired. This finding was reviewed with the Executive Director and the Director of Maintenance at the exit conference. 3.1-19(b)		How will the corrective action be monitored to ensure the deficient practice will not recur? The Maintenance Director will report no less than quarterly in perpetuity the results of the inspections in the Quality Assurance Performance Improvement meeting.	
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 record review, observation and interview; the facility failed to ensure 1 of 1 fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.	K 0521	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The fire damper will be inspected and provided with necessary maintenance. How will other residents having the potential to be affected by this same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have	06/13/2024

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	NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 05/13/2024 between 9:00 AM and 1:00 PM with the Director of Maintenance, a demand ticket dated 04/29/2024 indicated a damper in the facility "has proper fusible link operates freely" but no additional documentation regarding testing, maintenance, and location of the damper was available for review. Based on interview at the time of record review, the Director of Maintenance was unsure if the facility had dampers and the Regional Maintenance Director stated the facility may have a damper in the laundry room. This finding was reviewed with the Executive Director and Director of Maintenance at the exit conference. 3.1-19(b)		the potential to be affected by this deficient practice. Any residents in this area have the potential to be affected by this practice. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? An inspection of the damper shut down device, inspection and testing of fire dampers and smoke detectors will be completed in the TELS system every 48 months. How will the corrective action be monitored to ensure the deficient practice will not recur? The Maintenance Director will report no less than quarterly in perpetuity the results of the fire dampers and smoke detectors inspections in the Quality Assurance Performance Improvement meeting.	

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K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills for 2 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review with the Director of Maintenance on 05/13/2024 between 9:00 AM and 1:00 PM, no documentation for 3rd shift fire drills during the first quarter of 2024 and the fourth quarter of 2023 was available for review. Based on interview at the time of record review, the Director of Maintenance agreed there was no documentation regarding 3rd shift fire drills for the first quarter of 2024 and the fourth quarter of 2023. This finding was reviewed with the Director of Maintenance and the Executive Director at the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Maintenance Director will conduct quarterly fire drills on each shift under varied conditions. How will other residents having the potential to be affected by this same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. All residents have the potential to be affected by this practice. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? A Fire Drill Inspection will be completed in the TELS system for	06/13/2024

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			each shift staggered monthly. How will the corrective action be monitored to ensure the deficient practice will not recur? The Maintenance Director will report the results of the inspection no less than quarterly in perpetuity in the Quality Assurance Performance Improvement meeting.	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.			

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	A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure a minimum distance of at least five feet separated combustible materials from oxygen storage equipment in 1 of 1 oxygen storage areas. NFPA 99, Section 11.3.2.3 requires oxidizing gases such as oxygen shall be separated from combustibles by one of the following: (1) a minimum distance of 20 feet. (2) a minimum distance of 5 feet if the required storage location is protected by an automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. This deficient practice could affect any resident, staff or visitor in the vicinity of the oxygen storage and transfilling room. Findings include: Based on observation during a tour of the facility on 05/13/2024 between 1:00 PM and 5:45 PM with the Director of Maintenance, a cardboard box, wet floor sign, plastic bags, and medical gloves were	K 0923	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The cardboard box, wet floor sign, plastic bags and medical gloves were removed from the oxygen storage room. How will other residents having the potential to be affected by this same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Any residents in this area have the potential to be affected by this practice. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? Monthly inspections of the oxygen	06/13/2024

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	being stored within 5 feet of liquid oxygen containers and E-cylinders in the oxygen storage and transfilling room. Based on interview at the time of observation, the Director of Maintenance acknowledged combustible materials were stored within 5 feet of liquid oxygen containers. This finding was reviewed with the Executive Director and Director of Maintenance at the exit conference. 3.1-19(b)		systems, oxygen room signage and inspection will be completed monthly in the TELS system. How will the corrective action be monitored to ensure the deficient practice will not recur? The Maintenance Director will report no less than quarterly in perpetuity results of the inspections in the Quality Assurance Performance Improvement meeting.	