STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155668	A. BUILDING -- B. WING	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

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E 0000 Bldg. --	An Emergency Preparedness Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Dates: 10/07/24-10/08/24 Facility Number: 001144 Provider Number: 155668 AIM Number: 200256980 At this Emergency Preparedness survey, Charlestown Place at New Albany was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR Subpart 483.73. The facility has 172 total beds with 158 certified beds. At the time of the survey, the census was 141. The Assisted Living area was surveyed due to the lack of a 2 hour fire-rated separation between the skilled care areas and the Assisted Living areas. Quality Review completed on 10/17/24	E 0000	Allegation of Compliance Please accept the following plan of correction for the Life Safety Code Recertification and State Licensure Survey completed on October 8, 2024. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Surveyor; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the residents in our community. We respectfully request consideration for a desk review and paper compliance.	
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).	K 0000	Allegation of Compliance Please accept the following plan of correction for the Life Safety Code Recertification and State	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jesse Ray	Executive Director	11/08/2024

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

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	Survey Dates: 10/07/24-10/08/24 Facility Number: 001144 Provider Number: 155668 AIM Number: 200256980 At this Life Safety Code survey, Charlestown Place at New Albany 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 fully sprinkled. The facility has a fire alarm system with hard wired smoke detection in the corridors, spaces open to the corridors, plus hard wired smoke detectors with battery back up in all resident sleeping rooms and several staff offices connected to a panel at the Nurses' Station (not the main fire alarm control panel). The facility has a total capacity of 172 with 158 certified beds and had a census of 141 at the time of this visit. The Assisted Living area was surveyed due to the lack of a 2 hour fire-rated separation between the skilled care areas and the Assisted Living area. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 10/17/24		Licensure Survey completed on October 8, 2024. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Surveyor; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the residents in our community. We respectfully request consideration for a desk review and paper compliance.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility	K 0222	K-222	11/01/2024

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	failed to ensure the means of egress through 1 of 1 900 hall common areas and 1 of 1 egress doors by therapy was readily accessible for residents without a clinical diagnosis requiring specialized security measures.. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect 31 residents, staff and visitors in this smoke compartment. Findings include: Based on observations on 10/08/24 between 9:45 AM and 2:00 PM with the Maintenance Director, Executive Director, and Senior Vice President of Facilities, the egress exit door in the 900 hall common area and the egress exit near the therapy room did not have the door code posted and were not equipped with a 15-second delayed egress function. Based on interview at the time of observation, the Maintenance Director agreed the door codes in the aforementioned locations were not posted. This finding was reviewed with the Maintenance Director, Executive Director, and Senior Vice President of Facilities at the exit conference. 3.1-19(b)		1 1. No residents were found to be affected by the alleged deficient practice. Door codes were added to the therapy exit door and the 900 hall exit door (see attached images confirming compliance). 2 2. All residents have the potential to be affected by the alleged deficient practice and facility exit doors were reviewed to verify codes were posted as required. 3 3. The maintenance staff has been educated on the LSC requirements and NFPA standards regarding maintaining means of egress of obstructions and impediments for emergency use. 4 4. Means of egress will be audited at least monthly to validate that areas are continuously maintained free of obstructions or impediments for emergencies and to validate that door codes are properly posted as required. The monthly quality assurance and performance improvement committee will review the audits for compliance and make further recommendations as needed.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities 1. Based on observation and interview, the facility failed to ensure staff had access to the shutoff switch for 1 of 1 stove/oven in the therapy room. LSC 19.3.2.5.4 states within a smoke compartment,	K 0324	K-324 1. No residents were found to be affected by the alleged deficient practice. The attached Fusible	11/01/2024

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	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 of 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) and (13) are met. 19.3.2.5.3(9) states A switch meeting all of 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. (c) The switch is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. This deficient practice could impact at least 5 residents and staff. Findings include: During a tour of the facility with the Maintenance Director and Senior Vice President of Facilities, and the Executive Director, on 10/08/2024 between 9:45 AM and 2:00 PM, there was a cooktop stove/oven in the therapy room with the time displayed, indicating the cooktop stove/oven had power. The appliance was missing the dials. Based on interview at the time of observation, the Maintenance Director stated there was no emergency shut off for the appliance. Therapy staff stated when not in use, the dials are taken off		Safety Emergency Shutoff Switch along with a 45min electrical shutoff timer was installed for protection. Kitchen blocks were marked and installed to ensure kitchen equipment could be moved backed to the correct position under the kitchen hood extinguishing system. 2. All residents have the potential to be affected by the alleged deficient practice. 3. The maintenance staff have been educated on the LSC requirements and NFPA standards. 4. Facility appliances will be audited quarterly to validate proper use of electrical safety devices as required and proper positioning of kitchen equipment under kitchen hood extinguishing system. The monthly quality assurance and performance improvement committee will review the audits for compliance and make further recommendations as needed.	

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	the appliance and the door to therapy is closed and locked when staff is not present. The finding was reviewed with the Maintenance Director and Senior Vice President of Facilities, and the Executive Director at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2* Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice may affect at least 5 staff. Findings include:			

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	Based on observation during the tour with the Maintenance Director, Senior Vice President of Facilities, and the Executive Director on 10/08/24 between 9:45 AM and 2:00 PM, the electric wheeled flat grill which was located on the cooking line under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and cleaning. Based on interview with the Senior Vice President of Facilities stated other facilities he has have a way to address this. This finding was reviewed with the Maintenance Director, Senior Vice President of Facilities, and the Executive Director at the exit conference. 3.1-19(b)			
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to maintain the ceiling construction in the corridor near room 403 for 1 of 1 sprinkler heads in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff and at least 4 residents in the vicinity of the sprinkler head. Findings include: Based on observation with the Maintenance Director, Senior Vice President of Facilities, and Executive Director on 10/08/24 between 9:45 AM and 2:00 PM, the sprinkler head in the hall outside	K 0351	K-351 1 1. The sprinkler escutcheon outside of room 403 was replaced on 10/9/2024 (see attached image confirming compliance). 1.Facility sprinkler heads were reviewed to verify that there were no escutcheons missing, any areas needing correction were done so immediately. 2.The maintenance staff have been educated on the LSC and NFPA requirements for verifying that facility sprinkler escutcheons were in place appropriately. 3.Sprinkler heads will be audited monthly to validate that escutcheons were in place	11/01/2024

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	of room 403 was missing an escutcheon. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned sprinkler head was missing an escutcheon. This finding was reviewed with the Maintenance Director, Senior Vice President of Facilities, and Executive Director at the exit conference. 3.1-19(b)		properly. The monthly quality assurance and performance improvement committee will review the audits for compliance and make further recommendations as needed.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on record review, observation and interview, the facility failed to ensure 1 of 1 backflow prevention device in the sprinkler system piping was tested annually in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 13.6.2.1 states all backflow preventers installed in fire protection system piping shall be tested annually by conducting a forward flow test of the system at the designed flow rate, including hose stream demand, where hydrants or inside hose stations are located downstream of the backflow preventer. This deficient practice could affect all residents in the facility. Findings include: Based on record review with the Maintenance Director on 10/07/24 between 10:00 AM and 1:45 PM, documentation regarding the backflow preventer dated 05/20/24 indicated the backflow preventer was unable to be tested. Letters from SafeCare dated 08/16/2024 and 10/07/2024 indicated the necessary parts for the backflow	K 0353	K-353 1a. The Vice President of Plant Operations approved the quote for the Backflow Prevention Repairs on 10/17/2024 with Advanced Mechanical (see attached email correspondence and quote from service provider), completion of repairs to be completed as soon as possible. 2a. All residents have the potential to be affected by the alleged deficient practice. 3a. The maintenance staff has been educated on the LSC requirements and NFPA standards regarding the requirements of backflow prevention annual inspection. 4a. The Executive Director and/or Maintenance Director will audit Safecare's service and inspection portal monthly to verify inspections have been completed timely and supportive documentation provided.	11/01/2024

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	preventer have been ordered and have not been delivered yet. Based on interview at the time of observation, the Maintenance Director agreed the backflow preventer had not been tested in 2024 and the last backflow preventer test had been completed on 05/19/2023 This finding was reviewed with the Maintenance Director, Executive Director, and Senior Vice President of Facilities at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 900 hall common areas, 1 of 1 central supply rooms in the auditorium, 1 of 1 front entrance awnings, 1 of 1 mechanical rooms near room 208, 1 of 1 end of 800 hall. 1 of 1 200 hall patio, 1 of 1 ceiling areas near room 411, 1 of 1 therapy porch, 1 of 1 600 hall shower rooms, 1 of 1 kitchen dishrooms, 1 of 1 tool rooms, and 1 of 1 housekeeping storage rooms. 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 causes 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 and staff. Findings include: Based on observation during a tour of the facility on 10/8/2024 between 9:45 AM and 2:00 PM with the Executive Director, Maintenance Director, and		1b. The ceiling penetrations identified during the survey were corrected by 10/24/2024 (see attached images confirming compliance). 2b. All residents, staff, and visitors have the potential to be affected by the alleged deficient practice. Facility ceilings were inspected starting on 10/9/2024 by maintenance and areas identified were corrected immediately. 3b. The maintenance staff have been educated on immediate replacement of missing ceiling tiles and correcting ceiling penetration. 4b. The Executive Director and/or Maintenance Director will complete monthly audits to validate compliance. The monthly quality assurance and performance improvement committee will review the audits for compliance and make further recommendations as needed. 1c. The sprinkler heads identified during the survey were addressed and corrected on 10/9/2024 (see attached images confirming compliance). 2c. All residents, staff, and visitors have the potential to be affected by the alleged deficient practice. Facility sprinkler heads were inspected starting on 10/9/2024 by maintenance and areas identified were corrected immediately. 3c. The maintenance staff have	

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	Senior Vice President of Facilities the following was observed: a. a 4 inch by 2 inch penetration in the ceiling in the 900 hall common area near the exterior wall b. a 2 inch penetration in the ceiling in central supply in the auditorium above the metal pipe with a yellow handle c. a 4 inch rectangle penetration in the ceiling in central supply in the auditorium around the pipe next to the pipe with the yellow handle d. a 0.5 inch penetration around the large pipe for the water header in central supply in the auditorium e. a 0.5 inch square penetration in the ceiling of the front porch awning near the front door f. a 2 inch penetration in the ceiling of the mechanical room near room 208 around a pipe g. a 2 inch penetration in the ceiling at the end of the 800 hall h. a 1 inch penetration in the ceiling of the 200 hall patio i. a 0.5 inch penetration in the ceiling near room 411 j. a 2 by 2 inch penetration in the ceiling near the therapy porch k. a 2 inch penetration in the ceiling by the sink in the 600 hall shower room l. a 16 inch by 2 penetration in the ceiling of the dishroom m. a 2 inch penetration in the ceiling in the tool room n. a missing ceiling tile in housekeeping storage Based on interview at the time of observations, the Maintenance Director agreed there were penetrations in the ceiling in the aforementioned locations and provided the measurements. This finding was reviewed with the Maintenance Director, the Senior Vice President of Facilities		been educated on proper cleaning and/or replacement of sprinkler heads as required per NFPA 25 guidelines. 4c. The Executive Director and/or Maintenance Director will complete monthly audits to validate compliance. The monthly quality assurance and performance improvement committee will review the audits for compliance and make further recommendations as needed.	

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	and Executive Director at the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 3 of 3 sprinkler heads in the laundry area, 1 of 2 sprinkler heads behind the dryers, and 1 of 1 sprinkler heads on the porch near therapy which had objects on them were replaced in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states 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. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect at least 3 staff and residents. Findings include: Based on observation on 10/8/24 between 9:45 AM and 2:00 PM with the Maintenance Director, Senior Vice President of Facilities, and the			

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	Executive Director, 3 of 3 sprinkler heads in the laundry room area and 1 of 2 sprinkler heads behind the dryer were observed to be covered in lint. Additionally, 1 of 1 sprinkler heads on the porch just outside of therapy was observed to have a hard tan/brown colored substance on the sprinkler head prongs. Based on interview at the time of observation, the Maintenance Director stated housekeeping was supposed to be cleaning the sprinkler heads in the laundry area and that he believed the brown substance on the sprinkler head prongs on the porch near therapy was a mud dauber nest. The Maintenance Director agreed the sprinklers in the aforementioned locations were covered in foreign substances. When asked about the cleaning schedules for the sprinkler heads and lint traps in the laundry room area at 11:30 AM on 10/08/24, the Maintenance Director stated the sprinkler heads were cleaned weekly and provided a sign off sheet indicating the lint traps were to be cleaned hourly. Based on observation of the sign off sheet, the sheet had been signed off until 2:00 PM on 10/08/24. These findings were reviewed with the Maintenance Director, Senior Vice President of Facilities, and Executive Director during the exit conference. 3.1-19(b)			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to inspect 1 of 1 fire extinguishers in the copy room and 1 of 1 fire extinguishers in the 400 hall nurse's station med room each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be	K 0355	K-355 1. No residents were found to have been affected by the alleged deficient practice (see attached images confirming compliance). **1.All residents have the**	11/01/2024

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	inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push-to-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect at least 5 staff in these areas. Findings include: Based on observation during a tour of the facility on 10/08/24 between 9:45 AM and 2:00 PM with the Maintenance Director, Senior Vice President of Facilities and the Executive Director, the fire		**potential to be affected by the alleged deficient practice. All facility fire extinguishers were re-inspected in October and signed off as required.** **2.The maintenance staff has been educated on the LSC requirements and NFPA standards to perform monthly inspections of our fire extinguishers and initials recorded appropriately.** 4. The monthly quality assurance and performance improvement committee will review the audits for compliance and make further recommendations as needed.	

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	155668	A. BUILDING 01 B. WING	10/08/2024

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	extinguishers in the copy room and 400 hall nurse's station med room were not signed off for July, August, and September 2024. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned fire extinguishers had not been signed off for the aforementioned months. At the time of observation, the Maintenance Director signed the copy room fire extinguisher for July, August, and September 2024. This finding was reviewed with the Maintenance Director, Senior Vice President of Facilities and the Executive Director at the exit conference. 3.1-19(b)			
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure the penetrations through 1 of 1 smoke barrier walls near the north dining room and 1 of 1 300 hall smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect staff, 20 residents, and visitors in this smoke compartment. Findings include: Based on observation during a tour of the facility on 10/08/2024 between 9:45 AM and 2:00 PM with the Maintenance Director, Senior Vice President of Facilities, and the Executive Director, a penetration of 14 inches by 14 inches was located in the barrier wall near the north dining room and 3	K 0372	K-372 1. No residents were found to be affected by the alleged deficient practice. The penetrations identified in the attic barrier walls identified during the survey were corrected (see attached images confirming compliance). 2. All residents have the potential to be affected by the alleged deficient practice. Maintenance Staff reviewed attic barrier walls to verify penetrations had been sealed correctly as required. 3. The maintenance staff has been educated on the LSC requirements and NFPA standards regarding penetration through smoke barrier walls are properly protected to maintain the smoke	11/01/2024

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	penetrations were observed in the 300 hall barrier walls of 3 feet by 2 feet, 18 inches by 18 inches, and 6 inches by 3 inches. Based on interview at the time of observation, the Maintenance Director and Senior Vice President of Facilities stated they believed contractors created the 2 larger holes to bring items they need to complete their jobs through rather than using the door in the barrier wall. The Maintenance Director and Senior Vice President of Facilities provided the measurements. This finding was reviewed with the Maintenance Director, Senior Vice President of Facilities, and the Executive Director at the exit conference. 3.1-19(b)		resistance of each smoke barrier. 4. Attic smoke barriers will be reviewed after contractors have performed maintenance work in the attic to verify proper smoke barrier protection and at least quarterly to verify compliance. The monthly quality assurance and performance improvement committee will review the audits for compliance and make further recommendations as needed.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the 4 of 4 first shift fire drills, 4 of 4 second shift fire drills, and 3 of 4 third shift fire drills. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on record review on 10/07/24 between 10:00 AM and 1:45 PM with the Maintenance Director, the first shift fire drills were conducted at 11:30 AM, 11:15 AM, 12:00 PM, and 10:45 AM, the second shift fire drills were conducted at 1:50 PM, 2:30 PM, 3:07 PM, and 2:39 PM, the third shift fire drills were conducted at 5:30 AM, 5:00 AM, 5:18 AM, and 1:02 AM. Based on interview at the time of record review, the Maintenance Director stated he had been recently made aware that the times	K 0712	K-712 1 1. No residents were found to have been affected by the alleged deficient practice. 2 2. All residents, staff and visitors have the potential to be affected by the alleged deficient practice. Fire drills continue to be conducted on all shifts at unexpected times under various conditions. 3 3. The maintenance staff have been educated on the requirements of conducting monthly fire drills at unexpected times under various conditions. The Executive Director and/or Regional Director of Plant Operations will complete a monthly audit to validate ongoing	11/01/2024

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	would not be considered varied when the facility had conducted an internal life safety survey. This finding was reviewed with the Maintenance Director, Executive Director, and Senior Vice President of Facilities at the exit conference. 3.1-19(b) 3.1-51(c)		compliance. 4 4. The monthly quality assurance and performance improvement committee will review the audits for compliance and make further recommendations as needed.	
K 0761 SS=F Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA	K 0761	K-761 1 1. No residents were found to have been affected by the alleged deficient practice. The maintenance Director completed the annual fire door assembly inspection including oxygen rooms on 10/16/2024 (see attached inspections confirming compliance). 1.All residents have the potential to be affected by the alleged deficient practice. 3 3. The maintenance staff have been educated on the LSC requirements and NFPA standards regarding the annual required fire door assembly inspections to verify timely completion. 4 4. The monthly quality assurance and performance improvement committee will review the audits for compliance and make further recommendations as needed.	11/01/2024

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	80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 10/07/24 between 10:00 AM and 1:45 PM with the Maintenance Director, the last annual inspection was completed in May			

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	2023 and did not document a door assembly inspection for the oxygen room door. Based on interview at the time of record review, the Maintenance Director stated he was in the process of completing the fire door assembly inspection and acknowledged it had not been completed since May 2023. This finding was reviewed with the Maintenance Director, Senior Vice President of Facilities, and the Executive Director at the exit conference. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review, observation, and interview; the facility failed to document 36-month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents,	K 0918	K-918 1 1. No residents were found to be affected by the alleged deficient practice. The 36-month 4-hour emergency generator test is scheduled to be completed by Safecare on 11/1/2024 (see attached correspondence from Safecare confirming service). 2 2. All residents have the potential to be affected by the alleged deficient practice. 3 3. The maintenance staff has been educated on the LSC requirements and NFPA standards regarding the required emergency generator testing and frequency of testings. 4 4. The Executive Director and/or Maintenance Director will audit Safecare's service and inspection portal monthly to verify inspections have been completed	11/01/2024

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	staff, and visitors in the main building (Building 01). Findings include: Based on record review with the Maintenance Director on 10/07/24 between 10:00 AM and 1:45 PM, the thirty-six-month period emergency generator testing documentation for four continuous hours for the diesel fired emergency generator for the main building was not available for review. Based on interview at the time of record review, the Maintenance Director stated he was told that the facility did not need to complete a 4 hour load test. This finding was reviewed with the Senior Vice President of Facilities, the Executive Director, and the Maintenance Director during the exit conference. 3.1-19(b)		timely and supportive documentation provided.	