STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155162	A. BUILDING -- B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN RIDGE REHABILITATION CENTRE	600 WASHINGTON AVE WABASH, IN 46992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/12/24 Facility Number: 000081 Provider Number: 155162 AIM Number: 100289570 At this Emergency Preparedness survey, Autumn Ridge Rehabilitation Centre 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 75 and had a census of 33 at the time of this survey. Quality Review completed on 07/16/24	E 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or any violation of regulation. This provider respectfully requests that the 2567 POC be considered the letter of credible allegation. The facility respectfully requests a desk review in lieu of a revisit.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/12/24 Facility Number: 000081 Provider Number: 155162 AIM Number: 100289570 At this Life Safety Code survey, Autumn Ridge Rehabilitation Centre was found not in compliance with Requirements for Participation in	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or any violation of regulation. This provider respectfully requests that the 2567 POC be considered the letter of credible allegation. The facility respectfully requests a desk review in lieu of a revisit.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael Wolfe	Executive Director	08/06/2024

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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	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 three story facility was determined to be of Type II 111 construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery powered smoke detectors in the resident sleeping rooms. The facility has a capacity of 75 and had a census of 33 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 07/16/24			
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.			

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

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	on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 1. Based on observation and interview, the facility failed to ensure all exterior exit doors were readily accessible and able to open on first try. This deficient practice could affect all occupants in the facility. Findings include: Based on an observation and interviews during a tour of the facility with the Executive Director (ED) and the Maintenance Director from another building (MD) on 07/12/24 between 11:50 a.m. and 2:15 p.m., the service hall near the kitchen exit door would not open easily on the first try when tested. The Surveyor, then the MD tried to open the door, and the Maintenance Director was able, after several tries and considerable effort to open the door. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference. 2. Based on observation and interview, the facility failed to ensure the means of egress for 3 of the exit doors 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 all staff, residents	K 0222	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Door frame fixed and door closure adjusted for the kitchen exit door. Doors with a means of egress exit code was placed in area accessible to staff and residents. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents had the potential to be affected by this deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All exterior exit doors were tested to ensure doors opened easily and on first try by Maintenance Director. All exit doors with codes were audited to ensure codes were easily accessible by the Maintenance Director. The maintenance supervisor or designee will round weekly to ensure exit doors are easily open and codes are accessible.	07/15/2024

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	and visitors when needing to exit the facility. Findings include: Based on an observation and interviews during a tour of the facility with the Executive Director (ED) and the Maintenance Director from another building (MD) on 07/12/24 between 11:50 a.m. and 2:15 p.m., the following exit doors were posted with a code which was deemed too challenging to figure out in the event of an emergency requiring special knowledge to know where to look. The surveyor had to be shown where the code was posted above the door on the mechanism. A) Stairwell Exit door near RR# 309. B) Stairwell Exit door near RR# 315. C) Stairwell Exit door near RR# 301. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference. 3.1-19(b)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director. The Maintenance Director or designee will document on the Exit Door K222 QAPI tool weekly x4, monthly x6, and quarterly there after until compliance is achieved. If 100% compliance is not achieved an action plan will be developed. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** **7/15/24**	
K 0225 SS=E Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used			

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	as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Based on observation and interview, the facility failed to ensure 1 of 4 stairway enclosure doors were in accordance with 7.2. LSC Section 7.2.1.5.10 requires a latch or other fastening device on a door leaf to be provided with a releasing device that has an obvious method of operation and is readily operated under all lighting conditions. This deficient practice affects at least 10 residents staff and visitors. Findings include: Based on an observation and interviews during a tour of the facility with the Executive Director (ED) and the Maintenance Director from another building (MD) on 07/12/24 between 11:50 a.m. and 2:15 p.m., the latch on the 3rd floor stairwell exit door near RR# 309 was not functioning and the door failed to self-close and latch. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference. 3.1-19(b)	K 0225	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ="" p="">
Latch on stairwell exit door repaired- does self-close and latch How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents had the potential to be affected by this deficient practice. The maintenance supervisor or designee will complete an in-house audit of all stairwells exit doors to ensure further compliance What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Director/designee will check doors weekly to ensure stairwell exit doors self-close and latch How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place On-going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other	07/15/2024

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			month, and is overseen by the Executive Director. The Maintenance Director or designee will document on the Stairwell Exit Door K225 QAPI tool weekly x4, monthly x6, and quarterly there after until compliance is achieved. If 100% is not achieved an action plan will be developed By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. 7/15/24	
K 0321 SS=E 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			

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	the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor doors to 2 of over 8 hazardous rooms were 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 5 staff. Findings include: Based on an observation and interviews during a tour of the facility with the Executive Director (ED) and the Maintenance Director from another building (MD) on 07/12/24 between 11:50 a.m. and 2:15 p.m., the corridor doors to the following hazardous areas did not meet the requirements for protection of a hazardous area: a) Resident Room # 222, larger than 50 square feet and being used for storage, had a self-closing device on the door but it failed to self-close and latch positively into the door frame. b) Resident Room # 201, larger than 50 square feet	K 0321	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Latch on storage room door repaired- does self-close and latch for room 222 and room 201. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken All residents had the potential to be affected by this deficient practice. The Maintenance director or designee will complete an in-house audit of all storage doors to ensure further compliance What measures will be put into	07/15/2024

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	and being used for storage, had a self-closing device on the door but it failed to self-close and latch positively into the door frame. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference. 3.1-19(b)		place and what systemic changes will be made to ensure that the deficient practice does not recur; The Maintenance Director/designee will complete in house audit of all storage room doors to ensure storage room doors self-close and latch. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place On going compliance with the corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director. The Maintenance Director or designee will document on the Storage Door K321 QAPI tool weekly x4, monthly x6, and quarterly there after until compliance is achieved. If 100% compliance is not achieved an action plan will be developed By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of	

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			correction date. 7/15/24	
K 0325 SS=E Bldg. 01	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Based on observation and interview, the facility failed to ensure 1 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1-inch	K 0325	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ABHR moved away from the light switch in room 209.	07/15/2024

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	horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1-inch horizontal distance from the ignition source (c) Beneath an ignition source within a 1-inch vertical distance from the ignition source This deficient practice could affect 2 residents in one smoke compartment. Findings include: Based on an observation and interviews during a tour of the facility with the Executive Director (ED) and the Maintenance Director from another building (MD) on 07/12/24 between 11:50 a.m. and 2:15 p.m., an alcohol-based hand sanitizer dispenser was installed on the wall directly above a light switch in Resident Room # 209. Based on interview at the time of observation, the Executive Director confirmed the alcohol-based hand sanitizer dispenser was installed on the wall directly above switch. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference. 3.1-19(b)		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents had the potential to be affected by this deficient practice. The Maintenance director or designee will complete an in-house audit of all alcohol-based hand sanitizer dispensers above any electrical outlets/light switches to ensure further compliance. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; =”” p=””> Any new installation of ABHR will be observed to ensure it is not installed over an ignition source. The Maintenance Director will be inserviced on the appropriate location for installation of ABHR by the ED/Designee. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place On-going compliance with the corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director. The Maintenance Director or designee will document on the ABHR K325	

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			QAPI tool weekly x4, monthly x6, and quarterly there after until compliance is achieved. If 100% is not achieved an action plan will be developed. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. 7/15/24	
K 0353 SS=C 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.			

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	9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain the automatic sprinkler systems in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Section 13.3 requires control valves in water-based fire protection systems to be normally open. Section 13.3.2.1 requires all valves to be inspected weekly. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on an observation and interviews during a tour of the facility with the Executive Director (ED) and the Maintenance Director from another building (MD) on 07/12/24 between 11:50 a.m. and 2:15 p.m., the Post Indicator Valve (PIV) located outside the facility had a sight glass on each side which should normally indicate "OPEN". However, the glass on each side was so distorted from age that it could not be read. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference. 3.1-19(b)	K 0353	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Post Indicator Valve (PIV) sight glass replaced How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents had the potential to be affected by this deficient practice. PIV valve was replaced. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Sprinkler Contractor will inspect PIV annually to ensure the open /closed indicator is visible. Inspection will be documented and stored in TELS. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month. And overseen by the Executive Director. The Maintenance Director or designee will document the inspection of the	07/31/2024

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	155162	A. BUILDING 01 B. WING	07/12/2024

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			PIV in the TELS. If 100% compliance is not achieved, an action plan will be developed. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. 7/31/24	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 1 of 3 alcoves with a large quantity of combustible material open to the corridor was not used as hazardous storage. LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is	K 0361	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Lounge cleaned of all combustible materials How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;	07/15/2024

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	protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect 15 staff and residents. Findings include: Based on an observation and interviews during a tour of the facility with the Executive Director (ED) and the Maintenance Director from another building (MD) on 07/12/24 between 11:50 a.m. and 2:15 p.m., the second-floor lounge, open to the corridor was being used as storage containing several boxes and a pallet along with other combustible material. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference. 3.1-19(b)		All residents had the potential to be affected by this deficient practice The Maintenance Director or designee will complete an in-house audit of all lounges to ensure they are clear of combustible materials to ensure further compliance What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Staff inserviced to keep lounge areas cleaned of combustible materials by ED/Designee. Maintenance Director will round weekly to ensure lounges do not have any combustible materials located in the lounge area How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place On-going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and overseen by the Executive Director. The Maintenance Director or designee will document the Areas Open to Corridors K361 tool weekly x4, monthly x6, and quarterly there after until compliance is achieved. If 100% compliance is not achieved an action plan will be developed	

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			By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. 7/15/24	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that			

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	release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of over 20 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 6 staff and 6 residents. Findings include: Based on an observation and interviews during a tour of the facility with the Executive Director (ED) and the Maintenance Director from another building (MD) on 07/12/24 between 11:50 a.m. and 2:15 p.m., Resident Room #304 failed to latch positively into the door frame when tested at east 3 times. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference. 3.1-19(b)	K 0363	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; RR #304 repaired to latch How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Any Resident in this room had the potential to be affected by this deficient practice What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance Director or designee will complete an in-house audit of all resident doors	07/15/2024

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			to ensure they latch and ensure further compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month. And overseen by the Executive Director. The Maintenance Director or designee will document on the Doors K363 QAPI tool weekly x4, monthly x3 and quarterly there after until compliance is achieved. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. 7/15/24	
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			

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	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 fire drills on each shift for 1 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on records review and interviews with the Executive Director (ED) and the Maintenance Director from another building (MD) on 07/12/24 between 10:02 a.m. and 11:50 a.m., the following shifts were missing documentation of a completed fire drill: A) A second shift fire drill in the fourth quarter of 2023. B A third shift fire drill in the fourth quarter of 2023. Based on interview at the time of record review, both ED and MD stated the drills were likely not done since the facility was missing a Maintenance person about that time. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference.	K 0712	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; New Maintenance Director inserviced on Fire drills/documentation How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents had the potential to be affected by this deficient practice. New maintenance director was inserviced on fire drills/documentation What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance director will complete fire drills each quarter on different shifts, this will be reviewed by ED How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be	07/31/2024

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	3.1-19(b)		put into place On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month. And overseen by the Executive Director. The Maintenance Director or designee will document fire drills in the TELS. If 100% compliance is not achieved, an action plan will be developed. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. 7/31/24	