STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155224	A. BUILDING -- B. WING	09/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COLUMBIA HEALTHCARE CENTER	621 W COLUMBIA ST EVANSVILLE, IN 47710

(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: 09/18/23 Facility Number: 000129 Provider Number: 155224 AIM Number: 100266780 At this Emergency Preparedness survey, Columbia Healthcare 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 171 certified beds and had a census of 121 at the time of this visit. Quality Review completed on 09/26/23	E 0000	**Plan of Correction for Columbia Healthcare Center F000 Initial Comments** 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 of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of compliance and requests a desk review in lieu of a post survey review.	
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: 09/18/23 Facility Number: 000129 Provider Number: 155224 AIM Number: 100266780 At this Life Safety Code survey, Columbia	K 0000	**Plan of Correction for Columbia Healthcare Center F000 Initial Comments** 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 of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert O'Niones	Health Facility Administrator/ED	10/06/2023

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

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	Healthcare 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 two story facility with a basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and resident sleeping rooms in the 1400 hall (1403-1406, and 1408), and 2400 hall (2403-2410), plus battery operated smoke alarms in all other resident sleeping rooms. The facility has a capacity of 171 and had a census of 121 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered, except, one detached wood shed used for facility storage. Quality Review completed on 09/26/23		Allegation of compliance and requests a desk review in lieu of a post survey review.	
K 0100 SS=E 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 laundry area dryer room enclosure was free of lint. NFPA 101 at 19.1.1.3.1	K 0100	**K 100 General Requirements – Other** **What corrective action(s) will**	10/27/2023

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	states all health care facilities shall be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect mostly laundry staff. Findings include: Based on observations on 09/18/23 between 1:15 p.m. and 5:00 p.m. during a tour of the facility with the Maintenance Supervisor, Maintenance Assistant, and Senior Maintenance Supervisor, the floor, wall, and equipment in the back of the dryer enclosure within the laundry area was substantially covered with dryer lint. Based on interview at the time of observation, the Senior Maintenance Supervisor agreed there was a substantial amount of dryer lint on the floor, wall, and equipment within the enclosure behind the dryers, and further said they would increase the cleaning schedule. This finding was reviewed with the Administrator-in-Training, Maintenance Supervisor, Maintenance Assistant, and Senior Maintenance Supervisor during the exit conference. 3.1-19(b)		**be accomplished for those residents found to have been affected by the deficient practice?** No residents had a negative outcome due to this alleged deficient practice. **How will you identify either resident having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents under the care of the facility have the potential to be affected by the alleged deficient practices. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recure?** Preventative Maintenance (PM) has been enhanced to include inspections, documentation, cleaning monthly or as needed, and updated into the TELS PM system. The Maintenance Director has been in serviced on current cleaning schedule. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE: what quality assurance program will be put into place?** The maintenance director/designee will be responsible for the audit tool for dryer enclosure inspections weekly 4 times, and monthly	

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			times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 100% is not achieved, an action plan will be developed. **Date of Completion:** October 27, 2023	
K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. Based on observation and interview, the facility failed to ensure the protection of 1 of 15 stairway doors was in accordance of 19.3.1. LSC 19.3.1 requires vertical opening shall be enclosed or protected in accordance with Section 8.6. LSC 8.6.1 requires every floor that separates stories in a building shall be constructed as a smoke barrier. LSC 8.7.1.3 requires doors in barriers required to have a fire resistive rating shall have a minimum ¾ hour fire protection rating and be self-closing or	K 0311	**K 311 Vertical Openings – Enclosure** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents had a negative outcome due to this alleged deficient practice.	10/27/2023

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	automatic closing. This deficient practice affects over 20 residents, staff and visitors. Findings include: Based on observations on 09/18/23 between 1:15 p.m. and 5:00 p.m. during a tour of the facility with the Maintenance Supervisor, Maintenance Assistant, and Senior Maintenance Supervisor, the 2300 Unit stairway door was provided with a fire rating tag, however, it was covered with paint. This was confirmed by the Maintenance Supervisor and Senior Maintenance Supervisor at the time of observation. This finding was reviewed with the Administrator-in-Training, Maintenance Supervisor, Maintenance Assistant, and Senior Maintenance Supervisor during the exit conference. 3.1-19(b)		**How will you identify either resident having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents under the care of the facility have the potential to be affected by the alleged deficient practices. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recure?** The maintenance director is utilizing an additional form to ensure that Fire Rating Tag testing is completed annually. The forms are to be kept in binder in the Maintenance office and updated into the TELS PM system. Maintenance personnel have checked all doors to ensure that any paint that may have been on any Fire Rating Tags has been removed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE: what quality assurance program will be put into place?** The Maintenance Director/Designee will be responsible for the audit tool for the Fire Rating Tag inspections monthly times 4, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results	

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			of these audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 100% is not achieved, an action plan will be developed. **Date of Completion:** October 27, 2023	
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 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)			

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	e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of over 20 hazardous area doors, such as a storage room door, was provided with a self closing device. This deficient practice could affect mostly staff while in the staff training area. Findings include: Based on observations on 09/18/23 between 1:15 p.m. and 5:00 p.m. during a tour of the facility with the Maintenance Supervisor, Maintenance Assistant, and Senior Maintenance Supervisor, the Central Supply Room which opens into the staff training area, was over 50 square feet in size, and stocked with a large amount of cardboard boxes, paper, and plastic items. The door to this room was not provided with a self closing device. This was confirmed by the Senior Maintenance Supervisor at the time of observation. This finding was reviewed with the Administrator-in-Training, Maintenance Supervisor, Maintenance Assistant, and Senior Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0321	**K 321 Hazardous Areas – Enclosure** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents had a negative outcome due to this alleged deficient practice. **How will you identify either resident having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents under the care of the facility have the potential to be affected by the alleged deficient practices. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recure?** The Maintenance Director is utilizing an additional form to ensure all hazardous area doors have a self-closing device installed and inspected annually. Forms to be kept by Maintenance and updated into the TELS PM system. A door closer has been installed on the Central Supply	10/27/2023

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			door. All other high hazard storage areas have been inspected to ensure that door closers are in place to ensure safety and compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE: what quality assurance program will be put into place?** The Maintenance Director/designee will be responsible for the audit too for hazardous area enclosure inspections monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, and action plan will be developed. **Date of Completion:** October 27, 2023	
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			

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	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 2 stoves/ovens 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) 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 up to 20	K 0324	**K 324 Cooking Facilities** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents had a negative outcome due to this alleged deficient practice. **How will you identify either resident having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents under the care of the facility have the potential to be affected by the alleged deficient practices. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recure?** The Maintenance Director is utilizing an additional form to	10/27/2023

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	residents, staff and visitors in The Cottage. Findings include: Based on observations on 09/18/23 between 1:15 p.m. and 5:00 p.m. during a tour of the facility with the Maintenance Supervisor, Maintenance Assistant, and Senior Maintenance Supervisor, there was a cooktop stove/oven in The Cottage lounge/activity area. When asked, the Maintenance Supervisor pointed out the stove/oven disconnect in a cabinet to the side and below the stove/oven. The stove/oven was not being used at the time of observation and the power to the stove/oven was still on. Based on interview at the time of observation, the Maintenance Supervisor confirmed the cooktop stove/oven was not deactivated when not in use. This finding was reviewed with the Administrator-in-Training, Maintenance Supervisor, Maintenance Assistant, and Senior Maintenance Supervisor during the exit conference. 3.1-19(b)		ensure that the lock-out, tag-out power switch for the cooking device is functioning and operational. Forms to be kept by maintenance personnel and uploaded into TELS PO system. Memory Care Coordinator and pertinent staff on SCU in-serviced on proper use of the locked switch to power off cooktop. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE: what quality assurance program will be put into place?** The maintenance director/designee will be responsible for the audit tool to ensure that cook top is shut off when not being used/supervised. Audit inspections are monthly times 4, then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 100% is not achieved, an action plan will be developed. **Date of Completion:** October 27, 2023	
K 0345 SS=F	NFPA 101 Fire Alarm System - Testing and			

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Bldg. 01	Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm system was continuously in proper operating condition. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation on 09/18/23 between 1:15 p.m. and 5:00 p.m. during a tour of the facility with the Maintenance Supervisor, Maintenance Assistant, and Senior Maintenance Supervisor, there was a "Supervisory" yellow trouble light illuminated on the fire alarm control panel (FACP). Furthermore, the panel had a readout of "Active Track Superv. Dialer Trouble". Based on interview at the time of observation, this was confirmed by the Maintenance Supervisor, who further said the issue with the FACP does not stop the transmission of the alarm to the facility's monitoring company, and the facility is waiting for the fire alarm system inspection vendor to correct the issue. This finding was reviewed with the Administrator-in-Training, Maintenance Supervisor, Maintenance Assistant, and Senior Maintenance Supervisor during the exit conference.	K 0345	**K 345 Fire Alarm – Testing and Maintenance** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents had a negative outcome due to this alleged deficient practice. **How will you identify either resident having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents under the care of the facility have the potential to be affected by the alleged deficient practices. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recure?** Maintenance Director is utilizing an additional form to ensure that the fire observation panel and auto dialer system is always operational. Forms to be kept by	10/27/2023

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	3.1-19(b)		maintenance personnel and updated into the TELS PM system. Integrated Electronics Fire Protection has replaced the fire alarm cellular dialer to ensure that monitoring systems are functioning and up to date. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE: what quality assurance program will be put into place?** The maintenance director/designee will be responsible for the audit tool to ensure that the fire panel is operational and no trouble light present. Audit inspections are monthly times 4, then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 100% is not achieved, an action plan will be developed. **Date of Completion:** October 27, 2023	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic			

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	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) Based on observation and interview, the facility failed to provide an automatic sprinkler system that provided complete coverage in 1 of 17 smoke compartments. This deficient practice could affect mostly kitchen staff. Findings include: Based on observations on 09/18/23 between 1:15 p.m. and 5:00 p.m. during a tour of the facility with the Maintenance Supervisor, Maintenance Assistant, and Senior Maintenance Supervisor, there was an approximately 10 foot by 3 foot space on the left side of the walk-in cooler in back room of the kitchen being used as a storage area for over 20 cardboard boxes of cups, and other kitchen supplies. There was no sprinkler coverage for this space. Based on interview at the time of observation, the Senior Maintenance Supervisor agreed there was not enough sprinkler coverage for this space. This finding was reviewed with the	K 0351	**K 351 Sprinkler System – Installation** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents had a negative outcome due to this alleged deficient practice. **How will you identify either resident having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents under the care of the facility have the potential to be affected by the alleged deficient practices. **What measures will be put into place or what systemic changes you will make to**	10/27/2023

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	Administrator-in-Training, Maintenance Supervisor, Maintenance Assistant, and Senior Maintenance Supervisor during the exit conference. 3.1-19(b)		**ensure that the deficient practice does not recure?** The Maintenance Director is utilizing an additional form to ensure that the facility sprinkler system is maintained, tested, inspected, and maintained in accordance with NFPA. Forms to be kept by maintenance personnel and updated into the TELS PM system. Tri-State Fire Protection has replaced/installed the automatic sprinklers to ensure that systems are functioning and up to date. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE: what quality assurance program will be put into place?** The maintenance director/designee will be responsible for the audit tool to ensure that automatic sprinkler systems are inspected and maintained according to NFPA. Contracted and licensed contractors are to inspect the sprinklers on an annual basis at a minimum. Facility audit inspections are monthly times 4, then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 100% is not achieved, an action plan will be developed.	

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			Date of Completion: October 27, 2023	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure sprinkler heads in 2 of 17 smoke compartments covered with a foreign substance/loaded 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	K 0353	**K 353 Sprinkler System – Maintenance and Testing** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents had a negative outcome due to this alleged deficient practice. **How will you identify either resident having the potential to**	10/27/2023

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	the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect mostly maintenance and laundry staff. Findings include: Based on observations on 09/18/23 between 1:15 p.m. and 5:00 p.m. during a tour of the facility with the Maintenance Supervisor, Maintenance Assistant, and Senior Maintenance Supervisor, the following was noted: a. There was one of four sprinkler heads in the back room of the maintenance shop covered with a fire protection spray. This sprinkler head was located over the fuel fired water heaters. b. There was one sprinkler head in the laundry room dryer enclosure completely covered with dust/lint. Based on interview at the time of each observation, the Senior Maintenance Supervisor agreed there was a foreign substance on both sprinkler heads. This finding was reviewed with the Administrator-in-Training, Maintenance Supervisor, Maintenance Assistant, and Senior Maintenance Supervisor during the exit conference. 3.1-19(b)		**be affected by the same deficient practice and what corrective action will be taken?** All residents under the care of the facility have the potential to be affected by the alleged deficient practices. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recure?** The Maintenance Director is utilizing an additional form to ensure that the facility sprinkler heads are maintained, tested, inspected, and maintained. Forms to be kept by maintenance personnel and updated into the TELS PM system. Integrated Electronics Fire Protection has replaced the automatic sprinklers to ensure that systems are functioning and up to date. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE: what quality assurance program will be put into place?** The maintenance director/designee will be responsible for the audit tool to ensure that sprinkler heads are inspected and maintained. Licensed contractors are to inspect the sprinklers on an annual basis at a minimum. Facility audit inspections are monthly times 4, then quarterly	

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			until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 100% is not achieved, an action plan will be developed. **Date of Completion:** October 27, 2023	
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 Based on observation and interview, the facility failed to ensure 1 of 17 smoke compartments was maintained in accordance with 19.7.5.6. 19.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and	K 0753	**K 753 Combustible Decorations** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents had a negative outcome due to this alleged	10/27/2023

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	labeled for application to the material to which it is applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 19.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. (5)*They are decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present. This deficient practice could affect at least 2		deficient practice. **How will you identify either resident having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents under the care of the facility have the potential to be affected by the alleged deficient practices. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recure?** The Maintenance Director is utilizing an additional form to ensure that the facility is free of combustible decorations. Forms to be kept by maintenance personnel and updated into the TELS PM system. The identified combustible decorations have been removed from wall and smoke compartment. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE: what quality assurance program will be put into place?** The maintenance director/designee will be responsible for the audit tool to ensure that the facility is free of any combustible decorations. Facility audit inspections are monthly times 4, then quarterly until continued compliance is maintained for 2 consecutive	

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	residents, staff and visitors in 2300 Unit. Findings include: Based on observations on 09/18/23 between 1:15 p.m. and 5:00 p.m. during a tour of the facility with the Maintenance Supervisor, Maintenance Assistant, and Senior Maintenance Supervisor, in the 2300 Unit, there was a 12 foot by 3 foot picture collage on paper hanging on the corridor wall between resident rooms 2305 and 2307, and there was a 10 foot by 2 foot coloring picture on paper hanging on the corridor wall between resident rooms 2306 and 2308. Based on interview at the time of the observations, when asked, the Senior Maintenance Supervisor and Maintenance Supervisor agreed both items hanging on the wall in the 2300 Unit did not have a flame spread rating and have not been treated with any type of fire retardant material. This finding was reviewed with the Administrator-in-Training, Maintenance Supervisor, Maintenance Assistant, and Senior Maintenance Supervisor during the exit conference. 3.1-19(b)		quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 100% is not achieved, an action plan will be developed. **Date of Completion:** October 27, 2023	
K 0761 SS=F Bldg. 01	Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 15 of 15 stairway fire door assemblies, and 3 of 3 laundry chute door assemblies was 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	K 0761	**K 761 Maintenance, Inspection & testing – Doors** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents had a negative	10/27/2023

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	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, 5.2.4.1 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.		outcome due to this alleged deficient practice. **How will you identify either resident having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents under the care of the facility have the potential to be affected by the alleged deficient practices. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recure?** The Maintenance Director is utilizing an additional form to ensure that fire doors assemblies are inspected and tested annually in accordance with NFPA 80. Forms to be kept by maintenance personnel and updated into the TELS PM system. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE: what quality assurance program will be put into place?** The maintenance director/designee will be responsible for the audit tool to ensure that facility fire doors and other opening protectives are inspected per PM program. Facility audit inspections are monthly times 4, then quarterly until continued compliance is maintained for 2 consecutive	

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	(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 residents, as well as staff, and visitors. Findings include: Based on record review on 09/18/23 between 9:15 a.m. and 1:15 p.m. with the Maintenance Supervisor, Maintenance Assistant, and Senior Maintenance Supervisor present, the facility was able to provide documentation for the annual inspection of all sets of the facility's smoke barrier door assemblies and oxygen transfilling room fire door assembly, however, the facility was unable to provide documentation for an annual inspection of 15 stairway fire door assemblies and 3 laundry chute fire door assemblies. Based on interview at the time of record review, the Maintenance Supervisor said there was no documentation of an annual inspection of the facility's stairway and laundry chute fire door assemblies. Based on observations during a tour of the facility with the Maintenance Supervisor, Maintenance Assistant, and Senior Maintenance Supervisor between 1:15 p.m. and 5:00 p.m., there were 15 stairway fire door assemblies and 3 laundry chute fire door assemblies noted in the facility. This finding was reviewed with the Administrator-in-Training, Maintenance Supervisor, Maintenance Assistant and Senior Maintenance Supervisor during the exit conference.		quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 100% is not achieved, an action plan will be developed. **Date of Completion:** October 27, 2023	

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