STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING -- B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEWALK VILLAGE	1302 N LESLEY AVE INDIANAPOLIS, IN 46219

(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: 02/22/24 Facility Number: 000222 Provider Number: 155329 AIM Number: 100274950 At this Emergency Preparedness survey, Rosewalk Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 161 certified beds. At the time of the survey, the census was 104. Quality Review completed on 02/26/24	E 0000	**The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. The Facility formally requests a desk review of the following plans of correction.**	
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: 02/22/24 Facility Number: 000222 Provider Number: 155329 AIM Number: 100274950 At this Life Safety Code survey, Rosewalk Village was found not in compliance with Requirements	K 0000	**The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. The Facility formally requests a desk review of the following plans of correction.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Omar Khayyam Johnson	Executive Director	03/11/2024

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	155329	A. BUILDING 01 B. WING	02/22/2024

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	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 (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. Battery operated smoke detectors are installed in resident sleeping rooms. Smoke detectors hard wired to the fire alarm system are additionally installed in resident sleeping rooms 201 through 211. The facility has a capacity of 161 and had a census of 104 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except two detached wooden sheds providing facility storage. Quality Review completed on 02/26/24			
K 0100 SS=C 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 remove 1 of 3 essential electric system alarm remote annunciators which was in a location readily observed by operating personnel. LSC 4.6.12.3 requires existing life safety features	K 0100	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	03/08/2024

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	obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 2:05 p.m. on 02/22/24, one of the two remote annunciator panels located at the south nurse's station for the facility's emergency generator had no electrical power and failed to illuminate its warning lights when its test button was depressed multiple times. The inoperable annunciator panel was located within a yellow colored shell. The second remote annunciator panel for the emergency generator at the south nurse's station had electrical power and the warning lights for the panel illuminated when its test button was depressed. A third operable remote annunciator panel was located on the corridor wall at the north nurse's station. Nameplate information affixed to the emergency generator located outside the facility on the west side of the property indicated the unit was rated at 300 kW and was manufactured in February 2014. Based on interview at the time of the observations, the Maintenance Director and the Field Maintenance Supervisor stated the facility has one diesel fired emergency generator, the facility has two operable remote annunciator panels and agreed the yellow colored remote annunciator at the south nurse's station had no electrical power and should be removed. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit		·Facility to remove the essential electric system alarm remote annunciator. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. ·Annunciator was removed by Maintenance Director on 2/22/2024. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·An in-service will be completed by ED/Designee with maintenance personnel to ensure compliance with the requirements of this deficiency. **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?** ·The ED is responsible for ensuring the proper number of annunciators are located within the facility. ·The ED/designee will be responsible for monitoring or auditing the installation of future	

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	conference. 3.1-19(b)		annunciator as needed per replacement as required. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. . **By What date will the systematic changes be completed?** ·Compliance date 3/8/2024 **K 222 egress Doors- Code on door Memory Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Facility door located on the memory care unit to have code on keypad for entry and exit. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. ·Code to door was applied for both exit and entrance on 2/22/2024. **What measures will be put into**	

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			place or what systemic changes you will make to ensure that the deficient practice does not recur? ·An in-service will be completed by ED/Designee with maintenance personnel to ensure compliance for all required posting. **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?** ·Maintenance/ED will complete a POC CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 6 months by Maintenance/Designee. The POC CQI audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. of the responsible employee, the results 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. **·By What date will the systematic changes be completed?** ·Compliance date 3/8/2024	

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K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS			

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	Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 2 of 11 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. LSC Section 7.2.1.5.3 states locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 20 residents, staff and visitors.	K 0222	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Facility door located on the memory care unit to have code on keypad for entry and exit. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged	03/08/2024

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	Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 2:05 p.m. on 02/22/24, the corridor door set at the entrance to Auguste's Cottage was marked as a facility exit with an exit sign and was equipped with magnetic locking devices to keep the doors closed when the door set was in the fully closed position. The door set could be released to open by entering a code at a keypad, but the code was not posted at the keypad. The corridor door set at the facility exit to the outside of the facility by Room 123 was also marked as a facility exit and was also equipped with magnetic locking devices when the door set was in the fully closed position. The door set could be released to open by entering a code at the keypad, but the code was not posted. Based on interview at the time of the observations, the Maintenance Director and the Field Maintenance Supervisor agreed the code to release the door sets to open was not posted at the door sets but should be. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		deficient practice. ·Code to door was applied for both exit and entrance on 2/22/2024. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·An in-service will be completed by ED/Designee with maintenance personnel to ensure compliance for all required posting. **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?** ·Maintenance/ED will complete a POC CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 6 months by Maintenance/Designee. The POC CQI audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. of the responsible employee, the results 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.	

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			·By What date will the systematic changes be completed? ·Compliance date 3/8/2024	
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) 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)			

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	Based on observation and interview, the facility failed to ensure 3 of over 20 hazardous areas such as combustible storage rooms/spaces (over 50 square feet), soiled linen and trash collection rooms and boiler and fuel-fired heater rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 2:05 p.m. on 02/22/24, the corridor door to the Laundry Services room by Room 141 was equipped with a self-closing device but the door failed to fully self-close and latch into the door frame when tested to close multiple times. One 20-gallon capacity and one 32-gallon capacity soiled linen carts were stored in the room. In addition, resident sleeping Room 175 was converted to a storage and supply room for combustible boxes and supplies. The corridor door to the room was not equipped with a self-closing device. The annular space surrounding a two inch in diameter natural gas pipe which penetrated the ceiling of the natural gas fired water heater room across from the north nurse's station was not firestopped. Based on interview at the time of the observations, the Maintenance Director and the Field Maintenance Supervisor agreed the aforementioned three hazardous areas were not separated from other spaces with smoke resistant partitions and doors. These findings were reviewed with the Executive Director, the Maintenance Director and the Field	K 0321	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Facility to have all hazardous items behind doors with a self-closing device. ·Door 141 is affixed with a self-closing device. ·Door 175 is affixed with a self-closing device. ·The pipe that penetrated the ceiling is sealed with firestopped **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. ·All doors were inspected by maintenance director/designee to ensure the self-closing device was operational for storage room/spaces. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?** ·An in-service will be completed by ED/Designee with maintenance personnel to ensure compliance for all doors requiring self-locking devices. **How the corrective action (s)**	03/08/2024

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	Maintenance Supervisor during the exit conference. 3.1-19(b)		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·Maintenance/ED will complete a POC CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 6 months by Maintenance/Designee. The POC CQI audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. . **By What date will the systematic changes be completed?** ·Compliance date 3/8/2024	
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 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			

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	sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) 1. Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 2 storage rooms in the main dining room in accordance with LSC 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in Section 8.5.5.2 and Section 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the main dining room. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 2:05 p.m. on 02/22/24, cardboard boxes were stacked from the floor to the ceiling in the Dietary Storage room in the main dining room which obstructed the spray pattern for the one sprinkler in the room. Based on interview at the time of the observations, the Maintenance Director and the	K 0351	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·For the spray pattern for sprinkler head to not be obstructed. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. ·Boxes were removed from the storage room area. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·An in-service will be completed by ED/Designee with maintenance personnel to ensure compliance with all mandatory requirements for the Sprinkler System.	03/08/2024

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	Field Maintenance Supervisor agreed the stacked boxes in the room would obstruct the sprinkler spray pattern. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during 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 restrooms in Auguste's Cottage dining room 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 over 10 residents, staff and visitors in the vicinity of Auguste's Cottage dining room. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 2:05 p.m. on 02/22/24, one of one ceiling mounted sprinkler locations in the restroom in the Auguste's Cottage dining room had a missing escutcheon. Based on interview at the time of the observations, the Maintenance Director and the Field Maintenance Supervisor agreed the aforementioned sprinkler location was missing its escutcheon. These findings were reviewed with the Executive Director, the Maintenance Director and the Field		**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?** ·Maintenance/ED will complete a POC CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 6 months by Maintenance/Designee. The POC CQI audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed **By What date will the systematic changes be completed?** ·Compliance date 3/8/2024	

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	Maintenance Supervisor during the exit conference. 3.1-19(b)			
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 1 of over 100 sprinkler heads in the facility were not painted 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	K 0353	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Replacement of new sprinkler. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential	03/11/2024

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	(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 over 10 residents, staff and visitors in the vicinity of the storage room by Room 106. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 2:05 p.m. on 02/22/24, the deflector for the sprinkler located in the storage room by Room 106 was painted. Based on interview at the time of the observations, the Maintenance Director and the Field Maintenance Supervisor agreed the aforementioned automatic sprinkler location had paint on the deflector. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		to be affected by the alleged deficient practice. ·The sprinkler system is a dry system. Measurements of old sprinkler head conducted on 3/11/2024 for replacement on same day. ·All sprinkler heads were inspected by maintenance director/designee to ensure all were free from paint. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·An in-service will be completed by ED/Designee with maintenance personnel to ensure compliance with all mandatory sprinkler system requirements. **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?** ·Maintenance/ED will complete a POC CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 6 months by Maintenance/Designee. The POC CQI audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95%	

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			threshold is not achieved an action plan will be developed **By What date will the systematic changes be completed?** ·Compliance date 3/11/2024	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 1. Based on observation and interview, the facility failed to ensure 1 of 26 portable fire extinguishers was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could	K 0355	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Fire extinguisher in supply room by south nurse station will be inspected will be maintenance timely once a year. ·All fire extinguishers will be inspected annually. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. ·The fire extinguisher by South nurse station by supply room has been serviced.	03/08/2024

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	affect 10 residents, staff and visitors in the vicinity of the Nursing Supply room by the south nurse's station. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 2:05 p.m. on 02/22/24, the fire extinguisher inspection contractor had affixed a hanging tag to the ABC type portable fire extinguisher in the Nursing Supply room by the south nurse's station indicating the most recent annual inspection was performed in June 2022. Based on interview at the time of the observations, the Maintenance Director and the Field Maintenance Supervisor agreed the most recent annual inspection for the aforementioned portable fire extinguisher was more than one year old. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 26 portable fire extinguishers had the date of 6-year maintenance documented on each container in accordance with NFPA 10. NFPA 10, 2010 Edition, Section 7.3.1.1.2 states fire extinguishers shall be internally examined at intervals not exceeding those specified in Table 7.3.1.1.2. Section 7.3.1.2.1 states every six years, stored pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable internal examination procedure as detailed in the manufacturer's		·The fire extinguisher located in the classroom has been serviced. ·All fire extinguishers were inspected by maintenance director /designee to ensure all have been inspected at least annually. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·An in-service will be completed by ED/Designee with maintenance personnel to ensure compliance with all mandatory requirements for fire extinguishers maintenance. **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?** ·Maintenance/ED will complete a POC CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 6 months by Maintenance/Designee. The POC CQI audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed **By What date will the systematic changes be**	

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	service manual and this standard. Sections 7.3.3.1 through 7.3.3.2 state fire extinguishers that pass the applicable 6-year requirement shall have the maintenance information recorded on a durable weatherproof label that is a minimum size of 2 inches by 3.5 inches. The label shall be affixed to the shell and shall include the month and year the maintenance was performed. The label shall include the initials of the person performing the maintenance and the name of the agency performing the maintenance. A verification of service collar shall be located around the neck of the container indicating the month and year of service and the name of the agency performing the maintenance or recharge. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Classroom. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 2:05 p.m. on 02/22/24, the wall mounted ABC type portable fire extinguisher located in the Classroom was manufactured in 2008. The 6-year maintenance sticker and collar affixed to the container indicated the most recent 6-year maintenance was performed in July 2014. The fire extinguisher inspection contractor affixed an annual maintenance tag to the fire extinguisher indicating the most recent annual maintenance was performed in June 2023. Based on interview at the time of the observations, the Maintenance Director and the Field Maintenance Supervisor agreed 6-year maintenance for the portable fire extinguisher was overdue as of July 2020. These findings were reviewed with the Executive Director, the Maintenance Director and the Field		**completed?** ·Compliance date 3/8/2024	

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	Maintenance Supervisor during the exit conference. 3.1-19(b)			
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 1 DON offices was separated from the corridors by a partition capable of resisting the passage of smoke as required in a sprinklered building or met an Exception per 19.3.6.1(7). 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 protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Director of Nursing (DON) office by the main dining room. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 2:05	K 0361	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·The DON office will be equipped with an electrically supervised smoke detector. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. ·An electrically supervised smoke detector has been installed on 3/1/2024. **What measures will be put into place or what systemic changes you will make to ensure that the deficient**	03/08/2024

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	p.m. on 02/22/24, a sliding glass door was in the corridor wall to the DON office by the main dining room. The DON office was equipped with a corridor door and a ceiling mounted battery operated smoke detector, but the room was not equipped with an electrically supervised smoke detector. Based on interview at the time of the observations, the Maintenance Director and the Field Maintenance Supervisor agreed the sliding glass door to the DON office made the room open to the corridor, but the room was not equipped with an electrically supervised smoke detector. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		**practice does not recur?** ·An in-service will be completed by ED/Designee with maintenance personnel to ensure compliance for all mandatory requirements for areas open to corridor. **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?** ·Maintenance/ED will complete a POC CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 6 months by Maintenance/Designee. The POC CQI audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed **By What date will the systematic changes be completed?** ·Compliance date 3/8/2024	
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			

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	solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are 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 65 corridor doors to resident sleeping rooms would resist the passage of smoke. This deficient practice could affect over	K 0363	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	03/08/2024

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	10 residents, staff and visitors in the vicinity of resident sleeping Room 170. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 2:05 p.m. on 02/22/24, two separate 1/4th's inch in diameter holes were noted above and below the door handle for the corridor door to resident sleeping Room 170 which would not resist the passage of smoke. Based on interview at the time of the observations's, the Maintenance Director and the Field Maintenance Supervisor agreed the holes in the corridor door to resident Room 170 would not resist the passage of smoke. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		**practice?** ·Room 170 door to be completely smoke resistant. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. ·Holes in 170 door were sealed with fire proof caulking and will now resist the passage of smoke. ·All doors were checked by the maintenance director to ensure there were holes to prevent the passage of smoke. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·An in-service will be completed by ED/Designee with maintenance personnel to ensure compliance for all mandatory requirements for Corridor doors. **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?** ·Maintenance/ED will complete a POC CQI audit tool for six months with audits being	

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			completed once weekly for one month, and then monthly for 6 months by Maintenance/Designee. The POC CQI audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed **By What date will the systematic changes be completed?** ·Compliance date 3/8/2024	