STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155053	A. BUILDING -- B. WING	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF RUSHVILLE SKILLED NURSING FACILITY, THE	612 E 11TH ST RUSHVILLE, IN 46173

(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: 04/23/24 Facility Number: 000018 Provider Number: 155053 AIM Number: 100273930 At this Emergency Preparedness survey, The Waters of Rushville Skilled Nursing Facility was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 98 certified beds. At the time of the survey, the census was 36. Quality Review completed on 04/26/24	E 0000	**Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. This facility requests paperwork compliance.**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/23/24 Facility Number: 000018 Provider Number: 155053 AIM Number: 100273930 At this Life Safety Code survey, The Waters of	K 0000	**Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Diana Gore	Administrator	05/09/2024

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	155053	A. BUILDING 01 B. WING	04/23/2024

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	Rushville Skilled Nursing Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery-operated smoke detectors in all resident sleeping rooms. The healthcare portion of the facility has a capacity of 98 and had a census of 36 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinklered. The facility had two detached wooden storage buildings which were not sprinkled. Quality Review completed on 04/26/24		**This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. This facility requests paperwork compliance.**	
K 0131 SS=E Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8.			

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	o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 Based on observation and interview, the facility failed to ensure 1 of 1 separation fire doors would limit the spread of fire and restrict the movement of smoke. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.3.4.1 states every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. This deficient practice could affect 25 residents. Findings include: Based on observation and interview with the Administrator and the Maintenance Director (MD) on 04/23/24 between 11:45 a.m. and 2:20 p.m., the double set of barrier doors near Resident Room 61 did not close and latch. This set of doors separates the Skilled and Assisted Living sections of the facility. The MD acknowledged these barrier doors did not latch. The MD stated that one of the two doors appeared to be sticking on the carpet. This finding was acknowledged by the Administrator and Maintenance Director at the time of discovery and again at the exit conference with the Administrator and Maintenance Director	K 0131	**K131**– It is the intent of the facility to ensure separation fire doors would limit the spread of fire and restrict the movement of smoke to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On 4/24/24, the Maintenance Supervisor/designee repaired the double set of barrier doors near resident room 61 to ensure they close and latch to meet set standards. The Administrator verified the repair on 4/24/24 . **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. On 5/8/24, the Maintenance Supervisor/designee inspected all other areas and found no other negative findings. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 5/8/24, the Administrator inserviced the Maintenance Supervisor on the requirement to ensure to provide fire doors that	05/14/2024

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	present. 3.1-19(b)		would limit the spread of fire and to ensure they close and latch to meet set standards. b Maintenance Supervisor/designee will inspect all doors throughout the facility monthly to ensure they would limit the spread of fire and to ensure they close and latch as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure	

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			compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/14/24.**	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of over 4 corridor means of egresses were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice affects 8 residents in the facility.	K 0211	**K211**– It is the intent of the facility to ensure corridor means of egresses are continuously maintained free of obstructions to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 4/23/24, the Maintenance Supervisor/designee removed the nighstand in the corridor near the soiled utility room to meet set standards. The Administrator verified the work on 4/23/24 . 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**:	05/14/2024

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	Findings include: Based on observation and interview with the Administrator and the Maintenance Director (MD) on 04/23/24 between 11:45 a.m. and 2:20 p.m. in the corridor near the soiled utility room, a nightstand, which did not have wheels, was sitting in the corridor. Based on an interview at the time of observations, the MD stated the night stand would need to be moved. This finding was acknowledged by the Administrator and Maintenance Director at the time of discovery and again at the exit conference with the Administrator and Maintenance Director present. 3.1-19(b)		a On 5/8/24, the Administrator inserviced the Maintenance Supervisor/designee and all other staff will be inserviced on 5/14/24 on the requirement to ensure corridor means of egress are continuously maintained free of obstructions to meet set standards. b Maintenance Supervisor/designee will ensure corridor means of egress are continuously maintained free of obstructions as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system	

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			components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/14/24.**	
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			

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	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 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 1 of	K 0222	**K222**– It is the intent of the facility to ensure means of egress	05/14/2024

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	over 6 exits 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 over 15, staff and visitors if needing to exit the facility. Findings include: Based on observation and interview with the Administrator and the Maintenance Director (MD) on 04/23/24 between 11:45 a.m. and 2:20 p.m., the exit door #3, marked as a facility exit, was magnetically locked and could be opened by entering a four-digit code but the code posted was incorrect. This finding was acknowledged by the Administrator and Maintenance Director at the time of discovery and again at the exit conference with the Administrator and Maintenance Director present. 3.1-19(b)		through exits is readily accessible for residents without a clinical diagnosis required specialized security measures to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 4/25/24, the Maintenance Supervisor/designee posted the correct code at the exit door #3 to meet set standards. The Administrator verified the work on 4/25/24. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. On 5/8/24, the Maintenance Supervisor/designee inspected all doors and found no other negative findings. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 5/8/24, the Administrator inserviced the Maintenance Supervisor/designee to ensure the facility exit codes are posted correctly to meet set standards. b Maintenance Supervisor/designee will ensure the facility exit codes posted are correct facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review	

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			with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/14/24.**	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on interview and observation, it was	K 0291	**K291** – It is the intent of the	05/14/2024

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	determined that the facility failed to provide exterior emergency lighting for all exits. LSC Section 7.9.1.1 requires emergency lighting facilities for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect all occupants in the facility including staff, visitors and residents if the facility were required to evacuate in an emergency and the generator was providing electricity at that time. This deficient practice could affect everyone in the facility. Findings include: Based on observation and interview with the Administrator and the Maintenance Director (MD) on 04/23/24 between 11:45 a.m. and 2:20 p.m., it was unknown if the exterior lights for the exit discharge for all of the facility exits were connected to the generator. The MD was unsure and it was unclear from looking at the panels, and no further verification or documentation was available to verify the facilities exit lighting which would illuminate the exit discharges was connected to the generator and could illuminate in the event of a power outage. This finding was acknowledged by the Administrator and Maintenance Director at the time of discovery and again at the exit conference with the Administrator and Maintenance Director present. 3.1-19(b)		facility to ensure to provide exterior emergency lighting for all exits to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 5/9/24, the Maintenance Supervisor/designee ensured all the exterior exit lights are connected to the facility generator to meet set standards. The Administrator verified the work on 5/9/24. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 5/8/24, the Administrator inserviced the Maintenance Supervisor/designee on the requirement to ensure all facility exit lights are connected to the emergency generator and labeled and documented to meet set standards. 2.Maintenance Supervisor/designee will ensure all facility exit lights are connected to the generator as a part of the facility's monthly Preventive Maintenance Program and document those tests on the Battery-Operated Emergency Lights and signs Test Log and will maintain emergency lighting to meet set standards. If any issues are discovered, they will be addressed and resolved	

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			immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/14/24.**	
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			

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	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)			
	Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 3 staff and visitors. Findings include: Based on observation and interview with the Administrator and the Maintenance Director (MD)	K 0321	**K321** - It is the intent of the facility to ensure hazardous area doors are provided with properly working self-closing devices to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 4/25/24, the Maintenance Supervisor/designee removed all hazardous items from room 36 to meet set standards.	05/14/2024

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	on 04/23/24 between 11:45 a.m. and 2:20 p.m., RR # 36, greater than 50 square feet contained a number of combustible items, including 9 upholstered reclining chairs The corridor door to this room did not self-close and latch into the door frame. This finding was acknowledged by the Administrator and Maintenance Director at the time of discovery and again at the exit conference with the Administrator and Maintenance Director present. 3.1-19(b)		The Administrator verified the work on 4/25/24. **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 5/8/24, the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure hazardous areas have self-closing locked doors or that all hazardous items are removed to meet set standards. b Maintenance Supervisor/designee will inspect all hazardous area rooms throughout the facility to ensure they have working self-closing devices or hazardous items are removed as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4 MONITORING**	

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			CORRECTIVE ACTION: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/14/24.**	
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			

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	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 3 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 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 20 residents. Findings include: Based on observation and interview with the Administrator and the Maintenance Director (MD) on 04/23/24 between 11:45 a.m. and 2:20 p.m. an alcohol-based hand sanitizer dispenser was installed on the wall in the corridor directly above an electrical outlet by rooms #51, #16 and #14. Based on interview at the time of observation, the MD confirmed the alcohol-based hand sanitizer	K 0325	**K325**– It is the intent of the facility to ensure alcohol-based hand sanitizer dispensers are not installed over an ignition source to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On 4/26/24, the Maintenance Supervisor/designee relocated the alcohol-based hand sanitizer dispensers away from an ignition source near rooms 51, 16 and 14 to meet set standards. The Administrator verified the work on 4/26/24. **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. On 4/26/24, the Maintenance Supervisor/designee inspected the location of all alcohol-based hand sanitizer dispensers and found no other negative findings.	05/14/2024

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	dispenser was installed on the wall directly above an electrical outlets. This finding was acknowledged by the Administrator and Maintenance Director at the time of discovery and again at the exit conference with the Administrator and Maintenance Director present. 3.1-19(b)		**3 MEASURES TO PREVENT REOCCURRENCE**: a On 5/8/24, the Administrator inserviced the Maintenance Supervisor/designee on the requirement that alcohol-based hand sanitizers cannot be installed over ignition sources to meet set standards. b Maintenance Supervisor/designee will inspect all alcohol-based hand sanitizers throughout the facility monthly to ensure they are in the proper locations as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting.	

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			Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/14/24.**	
K 0761 SS=E Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of at least 1 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both	K 0761	**K761** – It is the intent of the facility to ensure annual inspection and testing of all fire door assemblies are completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 be permitted only in corridors and shall be protected by approved self-closing fire door assemblies to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 5/9/24, the Maintenance Supervisor/designee conducted the annual inspection for the fire door assembly at the Oxygen Transfilling Room and documented the inspection results on the Annual Door Inspections log to	05/14/2024

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	sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect 20 residents. Findings include: Based on records review and interview with the Administrator and the Maintenance Director (MD) on 04/23/24 between 9:50 a.m. and 11:45: a.m., no documentation of an annual inspection for the fire door assembly at the Oxygen Transfilling room was available for review. Based on observation during the tour the Oxygen Transfilling room has		meet set standards. The Administrator verified the inspections and documentation on 5/9/24. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 5/8/24 the Administrator/corporate Property Manager inserviced the Maintenance Supervisor/designee on the requirement that annual testing & inspections of fire door assemblies including the oxygen transfilling room must be conducted to ensure proper operation and documented on the Annual Door Inspections log to meet set standards. b Maintenance Supervisor/designee will conduct the annual inspection of fire door assemblies including the oxygen transfilling room to ensure proper operation and document the inspection results on the Annual Door Inspection log as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results.	

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	one 90-minute fire door assembly. Based on interview at the time of records review and observation, the MD stated the annual fire door inspection was not completed within the last year. This finding was acknowledged by the Administrator and Maintenance Director at the time of discovery and again at the exit conference with the Administrator and Maintenance Director present. 3.1-19(b)		c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance 5/14/24.**	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet			

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	the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5			
	1. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 1 staff in the boiler room. Findings include: Based on observation and interview with the Administrator and the Maintenance Director (MD) on 04/23/24 between 11:45 a.m. and 2:20 p.m. in the boiler area, an extension cord which was plugged into an outlet and then into another extension cord which appeared to go outside. The MD was unsure what the extension cords were powering, he speculated perhaps a sump. This finding was acknowledged by the Administrator and Maintenance Director at the	K 0920	**K920** – It is the intent of the facility to ensure flexible cords are not used as a substitute for fixed wiring and to ensure power strips are not used as a substitute for fixed wiring to provide power equipment with a high current draw to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 4/24/24 the Maintenance Supervisor/designee removed the extension cords from the boiler area to meet set standards. The Administrator verified the removal on 4/24/24. 2.On 4/24/24, the Maintenance Supervisor/designee removed a power strip from the West Nurses Station area to meet set standards. The Administrator verified the removal on 4/24/24.	05/14/2024

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	time of discovery and again at the exit conference with the Administrator and Maintenance Director present. 2. Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 2 residents and 2 staff in the nurses station. Findings include: Based on observation and interview with the Administrator and the Maintenance Director (MD) on 04/23/24 between 11:45 a.m. and 2:20 p.m. in the West Nurses Station area a power strip was being used to power a dorm style refrigerator (high power draw equipment). This finding was acknowledged by the Administrator and Maintenance Director at the time of discovery and again at the exit conference with the Administrator and Maintenance Director present. 3.1-19(b)		**2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. On 4/25/24 the Maintenance Supervisor/designee inspected all rooms throughout the facility for power strips and found no other negative findings. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 5/14/24, the Administrator inserviced the Maintenance Supervisor/designee/all other staff that flexible cords and power strips are not to be used as a substitute for fixed wiring to meet set standards. 2.Maintenance Supervisor/designee will inspect all rooms throughout the facility monthly to ensure they do not have flexible cords or power strips in use as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance	

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			documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/14/24.**	