STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155187	A. BUILDING -- B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

(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: 05/12/2021 Facility Number: 000098 Provider Number: 155187 AIM Number: 100290980 At this Emergency Preparedness survey, Golden Living Center - Fountainview Place was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 186 certified beds. At the time of the survey, the census was 117. Quality Review completed on 05/17/21	E 0000		
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: 05/12/2021 Facility Number: 000098 Provider Number: 155187 AIM Number: 100290980 At this Life Safety Code survey, Golden Living	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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	Center-Fountainview Place was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 483.90(a), Life Safety from Fire, the 2012 edition of the NFPA (National Fire Protection Association) 101, LSC (Life Safety Code), and 410 IAC 16.2. The building was surveyed with Chapter 19, Existing Health Care Occupancies. The original building was built in approximately 1978 and the addition, which consisted of 300 Hall, was built in approximately 2005. The entire building was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in all resident rooms. The facility is fully protected by a 350 kW diesel emergency generator. During the survey, C Wing (34 Rooms), and six rooms in D Wing, were under quarantine due to the COVID-19 Public Health Emergency. The number of rooms inspected was adjusted appropriately. The facility has a capacity of 186 dually certified for Medicare and Medicaid, and had a census of 117 at the time of this survey. Quality Review completed on 05/17/21			
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			

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	NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to maintain latching hardware on 1 of 11 smoke barrier doors per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect staff and at least 90 residents in the adjacent smoke compartments. Findings include: During a tour of the facility with the Corporate Director and Maintenance Director on 05/12/2021 the following were observed: a) At 12:30 p.m. a cross-corridor door, 1B, which had latching hardware failed to latch. Based on interview at the time of each observation, the Maintenance Director confirmed that the door did not latch when closing. This deficient finding was reviewed with the Corporate Executive at the time of exit. 3.1-19(b)	K 0100	1.What corrective action will be accomplished for those residents found to have been affected by deficient practice: The latching hardware on the smoke barrier door was repaired on 5.20.21. 1.How other residents that having the potential to be affected by the same deficient practice will be identified and what corrective action will be take: Whole house audit completed on all smoke door latching mechanisms and no other doors identified. 2.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance department educated on ensuring latching devices are effective on all smoke doors. 3.How the corrective action will be monitored to ensure the deficient practice will recur. What quality assurance program will be put into place: Maintenance Director/Designee will audit smoke barrier latches two times a week for 4 weeks, then weekly for 4 weeks, then monthly for 4 months. All audits will be submitted to QAPI monthly for 6 months with percentage of	05/28/2021

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			compliance. Modifications of frequency may be adjusted based on results.	
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			

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	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 1 secured egress door in the memory care unit was readily accessible for residents, staff, and visitors. NFPA LSC 19.2.2.2.5.2 allows for special locking arrangements for the clinical security needs of the patient provided all of the following are met: 1) Staff can readily unlock door at all times. 2) A total smoke detection system is provided in accordance with 9.6.2.9	K 0222	1.What corrective action will be accomplished for those residents found to have been affected by deficient practice: The memory Care Unit's egress door code is posted at the door on 5.20.2021. 1.How other residents that	05/28/2021

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	3) The building is protected throughout by an approved automatic fire sprinkler system. 4) The locks are electrical that fail safely to release upon loss of power. This deficient practice could affect all residents, staff, and visitors in the memory care unit. Findings include: During tour of the facility with the Corporate Executive and Maintenance Director on 05/12/2021 at 1:20 p.m., the egress door from the Memory Care Unit was secured by a magnetic lock and keypad. When a staff member assigned to the unit, was requested to unlock the door, she replied "I don't know the code." When asked if she would be readily able to open the door, she stated "The code is located in the Nurse's Station at the other end of the hall." Based on interview at the time of observation, the Corporate Executive and the Maintenance Director agreed that staff could not readily unlock the door. This deficient finding was reviewed with the Corporate Executive at the time of exit. 3.1-19(b)		having the potential to be affected by the same deficient practice will be identified and what corrective action will be take: Whole house audit completed on all egress door codes on 5.20.21 and all codes are posted. 2.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance department educated on egress door code posting requirements. 3.How the corrective action will be monitored to ensure the deficient practice will recur. What quality assurance program will be put into place: Maintenance Director/Designee will audit egress door code posting weekly for 4 weeks, then monthly for 5 months. All audits will be submitted to QAPI monthly for 6 months with percentage of compliance. Modifications of frequency may be adjusted based on results.	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by			

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	19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation, the facility failed to meet the clear width requirement for 2 of 7 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect 30 residents, staff and visitors if needing to exit the facility. Findings include:	K 0232	1. What corrective action will be accomplished for those residents found to have been affected by deficient practice: The lobby chair was removed on 5.12.2021 and the wooden bench in the corridor was secured to the wall on 5.12.21. 1.How other residents that having the potential to be affected by the same deficient practice will be identified and what corrective action will be take: Whole house audit completed on furniture in corridors on 5.20.21 and no other items identified. 2.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance department educated on secured/fixed furniture in corridor requirements. 3.How the corrective action will be monitored to ensure the deficient practice will recur, what quality assurance program will be put into place: Maintenance Director/Designee will audit secured/fixed furniture in corridors weekly for 4 weeks, then monthly for 5 months. All audits will be submitted to QAPI monthly for 6 months with percentage of compliance. Modifications of	05/28/2021

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	During a tour of the facility with the Corporate Executive and Maintenance Director from 12:15 p.m. to 2:45 p.m. on 05/12/2021, the following were found: a) An unsecured chair was found in the corridor near the main entrance. Based on interview at the time of observation, the Corporate Executive and the Maintenance Director agreed that the chair was in the corridor and it was unsecured. It was noted that this was corrected prior to the exit. b) An unsecured wood bench was in the corridor near the B wing nurse's station. It was observed that there was a cable on the leg of the bench, and an "eye" bolt was in the wall, however they were not secured together. Based on interview at the time of the observations, the Corporate Executive and the Maintenance Director agreed that the furniture was not secured to the wall or floor of the corridor. This deficient finding was reviewed with the Corporate Executive at the time of exit. 3.1-19(b)		frequency may be adjusted based on results.	
K 0321 SS=D 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			

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	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 1 hazardous areas such as fuel-fired heater rooms, laundry rooms larger than 100 square feet in size, soiled linen rooms, and combustible storage rooms over 50 square feet were protected in accordance with LSC Section 19.3.2.1. Section 19.3.2.1 states that any hazardous areas shall be safe-guarded by a fire barrier having a 1-hour fire-resistive rating or shall be provided with an automatic extinguishing system in accordance with Section 8.7.1. Where protected by sprinklers, the areas shall be separated from other spaces by smoke partitions in accordance with Section 8.4 and 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 staff in the kitchen. Findings include:	K 0321	1.What corrective action will be accomplished for those residents found to have been affected by deficient practice: The kitchen door hook was removed on 5.12.2021. 2.How other residents that having the potential to be affected by the same deficient practice will be identified and what corrective action will be take: Whole house audit completed on self-closing doors on 5.20.21 and no other doors identified. 3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance department educated	05/28/2021

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	During a tour with the Corporate Executive and the Maintenance Director on 05/12/2021, at 1:38 p.m. the kitchen dry goods storage room was a hazardous area. The door to the room was equipped with a self-closing device, however the device was circumvented as the door was held open by a manual hook. Based on interview at the time of observation, the Maintenance Director agreed that the door would not self close and was not held open by a device which would release the door upon activation of the fire alarm. This deficient finding was reviewed with the Corporate Executive at the time of exit. 3.1-19(b)		on self-closing door requirements. 4.How the corrective action will be monitored to ensure the deficient practice will recur, what quality assurance program will be put into place: Maintenance Director/Designee will audit 10 self-closing doors for devices to prop door open three times weekly for 4 weeks, then two times weekly for 4 weeks, weekly for 4 months.All audits will be submitted to QAPI monthly for 6 months with percentage of compliance. Modifications of frequency may be adjusted based on results.	
K 0353 SS=D Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.			

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	9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation, and interview; the facility failed to ensure sprinklers in two areas were replaced or cleaned in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect staff in the Central Supply room and Kitchen. Findings include: During a facility tour with the Corporate Executive and the Maintenance Director on 05/12/2021, the following was observed: a) At 1:00 p.m., 2 of 2 sprinklers in the Central Supply room were painted. b) At 1:35 p.m. 6 of 6 sprinklers in the kitchen were loaded with paint, grease, and lint or dust. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned	K 0353	1.What corrective action will be accomplished for those residents found to have been affected by deficient practice: The identified sprinkler heads were replaced/cleaned on 5.27.21. 2.How other residents that having the potential to be affected by the same deficient practice will be identified and what corrective action will be take: Whole house audit completed on sprinkler heads and cleaning schedule in place. 3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance department educated on sprinkler head requirements. 4.How the corrective action will be monitored to ensure the deficient practice will recur, what quality assurance program will be put into place: Maintenance Director/Designee will audit sprinkler heads weekly for 4 weeks, then monthly for 5 months. All audits will be submitted to QAPI monthly for 6 months with percentage of compliance. Modifications of frequency may be adjusted based on results.	05/28/2021

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	automatic sprinklers were painted or loaded with grease and lint or dust. This deficient finding was reviewed with the Corporate Executive at the time of exit. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that 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			

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	155187	A. BUILDING 01 B. WING	05/12/2021

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GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

(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
	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 2 room doors to the corridor were maintained in accordance with LSC Section 19.3.6.3. Section 19.3.6.3.5 states that corridor doors shall be provided with a means for keeping the door closed. Section 19.3.6.3.10 states that doors shall not be held open by devices other than those that release when the door is pushed or pulled. This deficient practice could affect all residents, staff, and visitors in the Administration Hall, and up to 30 residents in the adjacent smoke compartment. Findings include: During a tour of the facility with the Corporate Executive and the Maintenance Director, on 05/12/2021, the following conditions were found: a) At 12:40 p.m. the set of corridor doors for the Fireside Lounge failed to close and latch. The door was equipped failed to operate, and when tested, it did not ensure the proper leaf closed before the other leaf. b) At 1:25 p.m. the corridor door to Resident Room 336 did not latch into the frame when tested multiple times. Based on interview at the time of each observation, the Corporate Executive and Maintenance Director both agreed that the doors	K 0363	1.What corrective action will be accomplished for those residents found to have been affected by deficient practice: The resident rooms door was repaired on 5.20.21 and the corridor door leaf was repaired on 5.12.21. 2.How other residents that having the potential to be affected by the same deficient practice will be identified and what corrective action will be take: Whole house audit completed on resident and corridor doors and no others identified. 3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance department educated on resident and corridor closures requirements. 4.How the corrective action will be monitored to ensure the deficient practice will recur, what quality assurance program will be put into place:	05/28/2021

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	did not close and latch into the frame. It was noted that both findings were corrected prior to the exit. These deficient findings were reviewed with the Corporate Executive at the time of exit. 3.1-19(b)		Maintenance Director/Designee will audit resident doors and corridor leaf doors weekly for 4 weeks, then monthly for 5 months.All audits will be submitted to QAPI monthly for 6 months with percentage of compliance. Modifications of frequency may be adjusted based on results.	
K 0372 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure 12 of 12 smoke barrier walls were maintained in accordance with LSC Section 19.3.7.5. Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. Section 8.5.2 states that smoke barriers shall be continuous from outside wall to outside wall and continuous through all concealed spaces. Section 8.3.5.1 states that penetrations	K 0372	1. What corrective action will be accomplished for those residents found to have been affected by deficient practice: The 1 inch x 3 inch unsealed penetration was filled on 5.21.2021 and the fire block foam was removed and replaced with approved fire block on 5.24.2021. 2.How other residents that	05/28/2021

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	shall be protected by a firestop system or device tested to ASTM E 814, Standard Test Method for Fire Test of Through Penetration Fire Stops. This deficient practice could affect all building occupants. Findings include: During a tour of the facility with the Maintenance Director on 05/12/2021 from 2:00 p.m. to 2:45 p.m., the following conditions were found: a) At 2:00 p.m. a 1 inch X 3 inch unsealed penetration was found near HVAC flexible duct work through the B Wing Smoke Barrier above resident room 104. b) Smoke barriers throughout the building had penetrations sealed with a Fire Block foam spray that had been tested to ASTM E 814* (modified). Based on interview at the time of observation, the Maintenance Director agreed that Fire Block tested to ASTM E 814*, was modified and no longer met the requirements of NFPA LSC 8.3.5.1. This deficient finding was reviewed with the Corporate Executive at the time of exit. 3.1-19(b)		having the potential to be affected by the same deficient practice will be identified and what corrective action will be take: Whole house audit completed on correct fire caulk and smoke barrier penetrations and no others identified. 3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance department educated on correct fire caulk and penetration requirements. 4.How the corrective action will be monitored to ensure the deficient practice will recur, what quality assurance program will be put into place: Maintenance Director/Designee will audit smoke barrier door walls for penetration and fire caulk areas weekly for 4 weeks, then monthly for 5 months. All audits will be submitted to QAPI monthly for 6 months with percentage of compliance. Modifications of frequency may be adjusted based on results.	
K 0521 SS=C Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.			

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	18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation, and interview; the facility failed to ensure testing of fire dampers in the facility were properly documented in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Corporate Executive and Maintenance Director on 05/12/2021 at 12:15 p.m., the facility was able to provide documentation of a damper inspection, however the information was not complete. The information provided indicated the vendor completed the inspection on 08/15/2017.	K 0521	1.What corrective action will be accomplished for those residents found to have been affected by deficient practice: Damper documentation was completed timely but not available for review. New damper inspection completed on 5.21.2021. 2.How other residents that having the potential to be affected by the same deficient practice will be identified and what corrective action will be take: No other items identified. 3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance department educated on ensuring mandatory inspections are kept for review. 4.How the corrective action will be monitored to ensure the deficient practice will recur, what quality assurance program will be put into place: Maintenance Director/Designee will audit damper inspection monthly for 6 months. All audits will be submitted to QAPI monthly for 6 months with percentage of compliance. Modifications of frequency may be adjusted based on results.	05/28/2021

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	However, the documentation did not indicate the location of dampers, name of the inspector and deficiencies discovered. Based on interview at the time of record review, the Maintenance Director agreed that the documentation did not include the required information. This deficient finding was reviewed with the Corporate Executive at the time of exit. 3.1-19(b)			