STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155062	A. BUILDING -- B. WING	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LAPORTE CARE CENTER	1700 I STREET LA PORTE, IN 46350

(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: 03/23/23 Facility Number: 000023 Provider Number: 155062 AIM Number: 100289400 At this Emergency Preparedness survey, Brickyard Healthcare - Laporte Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 87 certified beds. At the time of the survey, the census was 63. Quality Review completed on 03/29/23	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: 03/23/23 Facility Number: 000023 Provider Number: 155062 AIM Number: 100289400 At this Life Safety Code survey, Brickyard	K 0000	The facility respectfully requests desk review/paper compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joe Flacke	Sr. Executive Director	04/07/2023

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	Healthcare - Laporte Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies. This one-story facility with a partial basement was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with hardwire smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in all resident rooms. The building is partially protected by a 125-kW diesel-powered generator. The facility has a capacity of 87 and had a census of 63 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for a block building used to store facility and maintenance equipment which was not sprinklered. Quality Review completed on 03/29/23			
K 0211 SS=D 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	K 0211	1. No residents were affected by	03/24/2023

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	failed to ensure 1 of 1 resident room closets were able to open from the inside if locked. LSC 19.2.2.1 states doors complying with 7.2.1 shall be permitted. 7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied. This deficient practice could affect 2 residents. Findings include: Based on observation with the Maintenance Director and the Administrator on 03/23/23 between 1:40 p.m. and 4:07 p.m., the closet in room 46 was locked with a slidebolt from the outside and there was no release from the inside to open the door if locked with the slidebolt. This condition could trap a person inside if locked from the outside. Based on interview at the time of observation, the Maintenance Director and the Administrator agreed the door was locked with an external lock and could not open from the inside when locked. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		the deficient practice. The slide bolt was removed from the closet door in room 46. 2. All residents have the potential to be affected by the deficient practice. No other resident rooms were noted to have external locks on their closet doors. 3. The administrator will perform a weekly audit of resident rooms for 4 weeks and then once per month for 5 months to make certain that no external locks have been attached to resident closet doors. Maintenance will do quarterly monitoring thereafter in perpetuity. 4. Audit results will be reviewed in the monthly QAPI meeting for a period of six months.	
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			

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	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 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			

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	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 4 exit doors in the facility were 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. LSC 7.2.1.5.3 requires if provided, locks shall not require of a key, a tool, or special knowledge or effort for operation from the egress side. This deficient practice could affect staff and residents in one smoke compartment Findings include: Based on observation with the Maintenance Director and Administrator on 03/23/23 between 1:40 p.m. and 4:07 p.m., the exit door for Entrance A and the North East exit door were both marked as a facility exit, were magnetically locked, and could be opened by entering a four-digit code on the access control pad, but the code was not posted within plain view and discretely posted.	K 0222	1. No residents were affected by the deficient practice. The exit door for Entrance A and the North East exit door that had exit codes that were not not posted within plain view, and discretely posted, were corrected by clearly labelling them and having the codes in plain view. 2. All residents, staff, and visitors have the potential of being affected by this deficient practice. All other exit doors within the facility were inspected and corrected accordingly. 3.The administrator will perform a weekly audit for 4 weeks and then once per month for 5 months to ensure that the exits are in compliance. 4. Audit results will be reviewed in the monthly QAPI meeting for a period of six months.	03/27/2023

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	Based on interview at the time of observation, the Maintenance Director agreed the codes to the doors were difficult to find and were not clearly posted. The findings were reviewed with Maintenance Director and Administrator during the exit conference. 3.1-19(b)			
K 0225 SS=E Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Based on observation and interview, the facility failed to maintain and keep dimensional uniformity for 1 of 2 stairways from the basement within the facility. LSC 7.2.2.3.6.1 states that variation in excess of 3/16" in the sizes of adjacent tread depths or in the height of adjacent risers shall be prohibited, unless otherwise permitted in 7.2.2.3.6.3. This deficient practice could affect 10 staff in the basement. Findings include Based on observation with the Administrator and Maintenance Director on 03/23/23 between 1:40 p.m. and 4:07 p.m., the stairway leading from A-hall to the basement had a noticeable riser height difference between the last two steps. When the steps were measured, the last step had a riser height of 7-1/2 inches tall. The step above measured 5-1/2 inches tall. A difference of two inches had been noted. Based on interview at the time of observation, the Maintenance Director agreed that the stairs measured more than a 3/16"	K 0225	1. No residents were affected by the deficient practice. A concrete landing pad will be poured to compensate for the difference in the riser height of the last step as compared to the rest of the steps. This landing pad will cover the width of the stairway and extend to a minimum length of 5 feet and will have a ramp added that will be 2 feet in length with a slope of no less than 12 inches of run to 2 inches of rise. Handrails will be added above the small ramp. 2. Staff and vendors have the potential of being affected by this deficiency. 3. No audits will be required after the correction of this deficiency. 4. Results of the correction will be reviewed in the monthly QAPI meeting that follows the completion of this project.	04/24/2023

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	difference in height. This finding was discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)			
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview; the facility failed to install exit signage in 1 of 2 corridors in the kitchen in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect 15 staff and residents in B-hall. Findings include: Based on observation with the Administrator and Maintenance Director on 03/23/23 between 1:40 p.m. and 4:07 p.m., the exit sign in B-hall indicated occupants to egress left away from the emergency exit. Based on observation, it was noted the	K 0293	1. No residents were affected by the deficient practice. The exit sign on B-wing has been repaired and currently depicts the correct egress path. 2. All residents, staff, and visitors have the potential of being affected by this deficient practice. All other exit signs within the facility were noted to be in compliance. 3. The maintenance director will perform a weekly audit for 4 weeks and then once per month for 5 months to ensure that all exit signs within the facility are in compliance. Maintenance will do quarterly monitoring thereafter in perpetuity. 4. Audit results will be reviewed in the monthly QAPI meeting for a period of six months.	03/24/2023

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	emergency exit was further down the hall. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and confirmed that the path of egress was not obvious. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)			
K 0321 SS=F Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons)			

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	e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 2 of 2 soiled utility areas were protected as a hazardous area with a self-closing door that would automatically latch into the frame. This deficient practice could affect 20 staff and residents in two smoke compartments. Findings include: Based on observations the Administrator and the Maintenance Director on 03/23/23 between 1:40 p.m. and 4:07 p.m., the soiled linen rooms for both C-wing near the therapy room and B-wing near the nurses station had soiled linen storage (which contained two soiled linen containers) which were not equipped with self-closing door devices. Based on interview at the time of observation, the Maintenance Director agreed the doors for soiled linen storage were not self-closing. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0321	1. No residents were affected by the deficient practice. The soiled linen carts were removed from the closets on the C and B halls and were stored in an approved areas with self-closing doors. 2. All residents, staff, and visitors have the potential of being affected by this deficient practice. An inspection of the facility did not reveal any other deficiencies related to the improper storage of soiled linen. 3. The administrator, or his designee, will perform an audit twice weekly for 4 weeks and then once weekly for 8 weeks, and then once per month for 3 months to ensure compliance. Maintenance will do quarterly monitoring thereafter in perpetuity. 4. Audit results will be reviewed in the monthly QAPI meeting for a period of six months.	03/23/2023
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small			

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	appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			
	Based on observation and interview, the facility failed to ensure 1 of 1 kitchen hood extinguishing system provided complete coverage for equipment that produces grease-laden vapors. NFPA 96, 2011 edition, Section 10.1.2 requires cooking equipment that produces grease-laden vapors and that might be a source of ignition of grease in the hood, grease removal device, or duct shall be protected by fire-extinguishing equipment. This deficient practice could affect at least 15 residents due to the kitchen was located in the same smoke compartment as the main entrance, lobby, and dining room. Findings include: Based on observation during a tour of the facility with the Maintenance Director and the Administrator on 03/23/23 between 1:40 p.m. and 4:07 p.m., a gas stove in use was not completely under the hood and was not covered by the suppression system. Based on interview at the time of observation, the Maintenance Director	K 0324	1. No residents were affected by the deficient practice. The gas stove was repositioned to be located completely under the hood and covered by the suppression system. 2. Residents have the potential to be affected by the deficient practice. 3. The maintenance director will perform a monthly audit for 6 months to ensure compliance. 4. Audit results will be reviewed in the monthly QAPI meeting for a period of six months.	03/23/2023

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	agreed that the stove was not completely covered by the extinguishing system. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)			
K 0351 SS=D 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 sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 facility office in accordance with 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 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate	K 0351	1. No residents or staff were affected by the deficient practice. All material in the DON's office was removed from the top shelf of the closet. 2. Residents and staff have the potential to be affected by the deficient practice. All other areas	03/23/2023

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	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 up to two staff. Findings include: Based on observation with the Maintenance Director and Administrator on 03/23/23 from 1:40 p.m. to 4:07 p.m., the closet in the DON office had storage touching or within 6 inches of the sprinkler head. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned sprinkler head was obstructed and would rearrange the materials within the closet. Findings were discussed with the Administrator and Maintenance Director at exit conference. 3.1-19(b)		within the facility were noted to be in compliance. 3. The administrator, or his designee, will perform an audit once weekly for 8 weeks and then once per month for four months to ensure compliance with the 18 inch rule. Maintenance will do quarterly monitoring thereafter in perpetuity. 4. Audit results will be reviewed in the monthly QAPI meeting for a period of six months.	
K 0353 SS=F 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			

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BRICKYARD HEALTHCARE - LAPORTE CARE CENTER	1700 I STREET LA PORTE, IN 46350

(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
	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 1. Based on observation and interview, the facility failed to ensure 1 of 4 sprinkler heads in laundry were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect 3 staff. Findings include: Based on observation during a tour of the facility with the Maintenance Director and Administrator on 03/23/23 between 1:40 p.m. and 4:07 p.m. a sprinkler head above the dryers in the laundry room showed signs of heavy loading of dust and foreign debris. Based on interview at the time of observation, the Maintenance Director confirmed the aforementioned sprinkler head showed dirt accumulation and loading. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)	K 0353	1. No residents were affected by the deficient practice. (1) The sprinkler head above the dryers was cleaned. (2) Missing and damaged ceiling tiles in the kitchen and laundry room were replaced with new ceiling tiles. (3) Curtain rods and curtains were removed from the scheduler's office. 2. Residents and staff have the potential to be affected by the deficient practice. 3. The maintenance director will perform a monthly audit for 6 months of all sprinkler heads to ensure compliance. Maintenance will do quarterly monitoring thereafter in perpetuity. The maintenance director will perform a monthly audit for 6 months of all ceiling tiles to ensure compliance. Maintenance will do quarterly monitoring thereafter in perpetuity. The administrator will perform an audit once per month for 6 months to ensure that no new curtains have been installed. 4. Audit results will be reviewed in	03/24/2023

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	2. Based on observation and interview, the facility failed to maintain the ceiling construction of 2 of 2 kitchen and laundry rooms. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice affects all staff in the basement Findings include: Based on observations during a tour of the facility with the Maintenance Director and Administrator on 03/23/23 between 1:40 p.m. and 4:07 p.m., in the suspended ceiling of the kitchen and laundry area, there was one ceiling tile missing and another with a three inch hole around a sprinkler head that exposed the ceiling about one foot above the suspended ceiling. This condition could delay the activation of the sprinklers installed on the suspended ceiling. Based on interview at the time of the observations, the Maintenance Director agreed there were missing and damaged ceiling tiles that could delay activation of sprinkler heads. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 3 of 3 curtains had clearance of at least 18 inches and was maintained below the level of the sprinkler deflectors in 1 of over 50 rooms. NFPA 25, 2011 Edition, Section 5.2.1.2 states the minimum clearance required by the		the monthly QAPI meeting for a period of six months.	

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	installation standard shall be maintained below all sprinkler deflectors. Further NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 edition, Section 8.6.5.2.2 states the distance from sprinklers to privacy curtains in light hazard occupancies shall be in accordance with Table 8.6.5.2.2 and Figure 8.6.5.2.2. Table 8.6.5.2.2 states suspended horizontal obstructions more than thirty inches in length shall maintain a minimum vertical distance below the sprinkler deflector of 18 inches. Section 8.6.5.2.2.1 states, in light hazard occupancies, privacy curtains shall not be considered obstructions where all of the following are met: (1) The curtains are supported by fabric mesh on ceiling track. (2) Openings in the mesh are equal to 70 percent or greater. (3) The mesh extends a minimum of 22 inches down from the ceiling. This deficient practice could affect 12 staff and residents near the Scheduler's office. Finding includes: Based on observations with the Maintenance Director and Administrator during a tour of the facility from 1:40 p.m. to 4:07 p.m. on 03/23/23, three privacy curtains in the Schedulers Office was hung on a horizontal rod with the top of the curtain installed 4 inches from the ceiling. The office area was provided with a sprinkler, but the sprinkler coverage was blocked by the curtains in the Schedulers office. The curtains were not provided with a fabric mesh at the top to allow proper sprinkler coverage. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned privacy curtains were hung 4 inches from the ceiling which caused a sprinkler spray pattern			

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	obstruction less than 18 inches from the ceiling. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)			
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 Based on observation and interview, the facility failed to ensure 2 of 14 portable fire extinguishers were not obstructed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.3 states portable fire extinguishers shall not be obstructed or obscured from view. This deficient practice could affect all staff in the basement. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Administrator on 03/23/23 between 1:40 p.m. and 4:07 p.m., two ABC portable fire extinguishers located in the laundry room and boiler room were blocked by linen carts and a tool chest. Based on interview at the time of observation, the Maintenance Director acknowledged the blocked fire extinguishers in both rooms. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)	K 0355	1. No residents or staff were affected by the deficient practice. The linen cart in the laundry room was removed from in front of the portable fire extinguisher and the tool box that was blocking access to the portable fire extinguisher in the boiler room was also removed and relocated. 2. Residents and staff have the potential to be affected by the deficient practice. No other portable fire extinguishers within the facility had objects blocking them. 3. The maintenance director will perform an audit weekly for 4 weeks and then once per month for 5 months to ensure compliance. Maintenance will do quarterly monitoring thereafter in perpetuity. 4. Audit results will be reviewed in the monthly QAPI meeting for a period of six months.	03/23/2023

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K 0363 SS=F 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 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			

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	Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. 1. Based on observation and interview, the facility failed to ensure 3 of 30 corridor doors in the facility were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect all staff and residents Findings include: Based on a tour of the facility with the Administrator and Maintenance Director on 03/23/23 between 1:40 p.m. and 4:07 p.m., the following deficiencies were noted: a) The door to resident room 10 did not completely latch into the frame when tested three times. b) The set of double doors in the corridor of B-wing did not have positively latching hardware and would not completely stay closed and latched when tested. c) The set of double doors for a closet in C-hall did not have positive latching hardware and would not completely stay closed and latched when tested. The findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 2 doors to the corridor would completely resist the passage of smoke. This deficient practice could affect approximately 18 residents, as well as staff and visitors. Doors	K 0363	1. No residents were affected by the deficient practice. (1) (a) The door set for room 10 was replaced and is now latching properly. (b) The set of double doors (closet) in the corridor of B-wing had the latching hardware repaired and is now staying latched and closed. (c) The set of double doors (closet) in the corridor of C-wing had the latching hardware repaired and is now staying latched and closed. Holes located in the doors of the utility room located on A-wing and the cable room on B-wing have been repaired. 2. Residents have the potential to be affected by the deficient practice. 3. The maintenance director will check resident doors and closet doors for proper operation and holes once per week for 4 weeks and once per month for 5 months. 4. Audit results will be reviewed in the monthly QAPI meeting for a period of six months.	03/28/2023

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	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 for 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 flames in window assemblies. This deficient practice could affect all residents and staff in two smoke compartments. Findings include: Based on observation on 03/23/23 between 1:40 p.m. and 4:07 p.m. during a tour of the facility with the Maintenance Director and Administrator, the door to the utility room in A-hall had a one-half inch half-moon shaped hole above the handle to			

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	the door that opened to the corridor. Furthermore, the door to the cable room in B-hall had a one-half inch hole on the top right corner of the door. At the time of observations, the Maintenance Director stated that the latching and closing hardware had been changed and holes had not been covered. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)			
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure 1 of 3 electrical outlets in the schedulers office was protected. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect 2 staff. Findings include: Based on observation during a tour of the facility with the Maintenance Director and Administrator on 03/23/23 between 1:40 p.m. and 4:07 p.m., the outlet behind a desk in the schedulers office was broken and on the floor leaving the electical outlet exposed. Based on interview at the time of	K 0511	1. No residents or staff were affected by the deficient practice. The outlet cover for the receptacle behind the scheduler's desk was replaced and the receptacle and outlet cover next to the table in the conference room were both replaced. 2. Residents and staff have the potential to be affected by the deficient practice. All other receptacles and outlet covers were in place and in compliance. 3. The maintenance director will perform a weekly audit of receptacles and outlet covers for 4 weeks and then once per month	03/24/2023

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	observation, the Maintenance Director acknowledged the aforementioned condition. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 6 electrical outlets in the conference room were free from hazards arising from the use of electricity . LSC 19.1.1.3.1 states all health care facilities shall be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect staff in the conference room. Findings include: During a tour of the facility with the Administrator and Maintenance Director on 03/23/23 between 1:40 p.m. and 4:07 p.m., an electrical outlet next to the conference table had black charring around one of the plug holes. Upon interview at the time of observation, the Maintenance Director stated he was unaware of the issue and stated no fires have happened within the building. Findings were discussed with the Administrator and Maintenance Director at exit conference.		for 5 months to ensure compliance. Maintenance will do quarterly monitoring thereafter in perpetuity. 4. Audit results will be reviewed in the monthly QAPI meeting for a period of six months.	
K 0741 SS=F Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is			

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	used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on observation and interview; the facility failed to ensure 2 of 3 areas within the facility were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observation during a tour of the facility with the Maintenance Director and Administrator on 03/23/23 between 1:40 p.m. and 4:07 p.m., the following deficiencies were noted: a) The sidewalk next to the generator outside of the building had over 20 cigarette butts on the ground. b) Outside of Entrance A had over 15 cigarette	K 0741	1. No residents were affected by the deficient practice. a) The sidewalk next to the generator outside of the building had over 20 cigarette butts on the ground. The area has been cleared of all butts. b) Outside of Entrance A had over 15 cigarette butts on the ground. The area has been cleared of all butts. c) The designated smoking area in the courtyard under the gazebo had approximately 15 cigarette butts on the ground. The area has been cleared of all butts. 2. Residents have the potential to	04/12/2023

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	butts on the ground. c) The designated smoking area in the courtyard under the gazebo had approximately 15 cigarette butts on the ground These findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		be affected by the deficient practice. All other areas around the building were inspected and cleared of any cigarette butts. Staff and resident smokers have been educated on the importance of the proper disposal of their cigarette butts. 3. The maintenance director will inspect all outside area around the building and within the courtyards to ensure there are not any cigarette butts. This audit will be performed daily for 4 weeks and then weekly for 5 months. 4. Audit results will be reviewed in the monthly QAPI meeting for a period of six months.	
K 0751 SS=D Bldg. 01	NFPA 101 Draperies, Curtains, and Loosely Hanging Fabr Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1 Based on observation and interview, the facility failed to ensure that 3 of 3 curtains were installed and properly maintained. LSC 19.7.5.1 states that Draperies, curtains, and other loosely hanging	K 0751	1. No residents were affected by the deficient practice. All rods and curtains (3) were removed from the scheduler's office.	03/24/2023

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	fabrics and films serving as furnishings or decorations in healthcare occupancies shall be in accordance with the provisions of 10.3.1, and the following also shall apply: (1) such curtains shall include cubicle curtains (2) Such curtains shall not include curtains at showers and baths (3) Such draperies and curtains shall not include draperies and curtains at windows in patient sleeping rooms in smoke compartments sprinklered in accordance with 19.3.5 (4) Such draperies and curtains shall not include draperies and curtains in other rooms or areas where the draperies and curtains comply with all of the following (a) Individual drapery or curtain panel area does not exceed 48 square feet (b) Total area of drapery and curtain panels per room or area does not exceed 20 percent of the aggregate area of the wall on which they are located (c) Smoke compartment in which draperies or curtains are located is sprinklered in accordance with 19.3.5. LSC 10.3.1 states where required by the applicable provisions of this code, draperies, curtains, and other similar loosely hanging furnishings and decorations shall meet the flame propagation performance criteria contained in NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice could affect 2 staff in the Scheduler's Office. Findings include: Based on observation with the Maintenance Director and Administrator, three curtains were installed and hanging in the Scheduler's office separating the room. When inspecting the curtains, no tag or identifier was labeled to determine if the curtains met NFPA 701 regulations. Based on interview at the time of observation, the Maintenance Director stated that they were unaware if the curtains had a flame		2. All residents have the potential to be affected by the deficient practice. No other curtains/draperies have been installed within the facility over the last several years. 3. The administrator will perform a monthly audit for 6 months to ensure that any new curtains/draperies that are installed are properly mounted and have an appropriate fire rating. 4. Audit results will be reviewed in the monthly QAPI meeting for a period of six months.	

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	155062	A. BUILDING 01 B. WING	03/23/2023

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	spread rating or treated with fire resistive material. Findings were discussed with the Maintenance Director and Administrator at exit conference.			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design			

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	consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on observation and interview, the facility failed to ensure 1 of 1 emergency task generator battery backup lights was provided. NFPA 110, 2010 Edition at section 7.3.1 requires the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access. This deficient practice could affect all residents in the facility. Findings include: Based on record review on with the Maintenance Director and Administrator on 03/23/23 between 1:40 p.m. and 4:07 p.m., the generator, located in the courtyard, was not provided with a battery-powered light.. Based on an interview at the time of record review, the Maintenance Director agreed that there was not a battery-powered light installed for the generator. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)	K 0918	1. No residents or staff were affected by the deficient practice. A battery light was installed on the generator. 2. Residents have the potential to be affected by the deficient practice. 3. The maintenance Director will perform a monthly audit for 6 months to ensure that the battery operated light is in place and functioning. The light will be inspected for 30 seconds monthly and 90 minutes annually. Testing will be maintained in building engines in perpetuity. 4. Audit results will be reviewed in the monthly QAPI meeting for a period of six months.	03/28/2023
K 0920 SS=D 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 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect 1 staff. Findings include: Based on observation with the Maintenance Director and Administrator on 03/23/23 between 1:40 p.m. and 4:07 p.m., in the Medical Records office, a power strip used to power equipment, was not secured, and was dangling off the side of the desk. This condition could put stress on the	K 0920	1. No residents or staff were affected by the deficient practice. The dangling power strip was removed and secured on the floor. 2. Residents and staff have the potential to be affected by the deficient practice. No other power strips were found to be not properly secured within the facility. 3. The maintenance director will perform a weekly audit for 4 weeks and then once monthly for 5 months to ensure compliance. 4. Audit results will be reviewed in the monthly QAPI meeting for a period of six months.	03/23/2023

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	power cord causing damage to the power cord. Based on interview at the time of observations, the Maintenance Director agreed the power strip was dangling, not secured, and stated the power strip will need to be mounted or set on the floor. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)			
K 0927 SS=F Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) 1. Based on records review and interview, the facility failed to ensure staff was properly trained on trans-filling procedures in 1 of 1 oxygen storage room where oxygen transferring takes place. NFPA 99 2012 edition, 11.5.2.3.1 (4) the individual trans-filling the container(s) has been properly trained in the trans-filling procedures. This deficient practice could affect up to 10 residents in one smoke compartment. Findings include:	K 0927	1. No residents were affected by the deficient practice. (1) The nursing staff will be properly in-serviced on the trans-fill of liquid oxygen. All documentation will be completed by 4/12/2023. (2) The fan in the oxygen room has been repaired. 2. Residents and staff have the potential to be affected by the deficient practices. 3. The maintenance director will	04/12/2023

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	Based on records review with the Maintenance Director and Administrator on 03/23/23 between 1:40 p.m. and 4:07 p.m., no documentation was available for review to indicate staff that trans-fill liquid oxygen were properly trained. Based on interview at the time of record review, the Administrator stated staff are trained during orientation but was unable to provide paperwork at the time of the survey. Findings were discussed with the Administrator and Maintenance Director at exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room where oxygen transferring takes place, was provided with properly working mechanical ventilation. NFPA 99 2012 edition, 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical exhaust to maintain a negative pressure in the space continuously. This deficient practice could affect 20 staff and residents in one smoke compartment. Findings include: Based on observation during a tour of the facility the Maintenance Director and Administrator on 03/23/23 between 1:40 p.m. and 4:07 p.m., the oxygen storage/transfer room contained large liquid oxygen tanks. There was one vent to the outside and was used for mechanical ventilation, but when examined the fan was not working. Based on interview at the time of observation, the Maintenance Director stated the oxygen room had a direct vent to the outside but the mechanical fan was not working when tested.		perform a weekly audit for 4 weeks and then once per month for 5 months to ensure the functionality of the fan. Maintenance will do quarterly monitoring thereafter in perpetuity. 4. Audit results will be reviewed in the monthly QAPI meeting for a period of six months.	

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	Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)			