STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING -- B. WING	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCLIFF HEALTH & REHABILITATION CENTER	5024 WESTERN AVENUE SOUTH BEND, IN 46619

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E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 06/03/21 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/29/21 Facility Number: 013420 Provider Number: 155831 AIM Number: 201293620 At this Emergency Preparedness survey, Briarcliff Health and Rehabilitation Center was found to be in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 111 certified beds. At the time of the survey, the census was 55. Quality Review completed on 08/03/21	E 0000		
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 06/03/21 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/29/21 Facility Number: 013420 Provider Number: 155831	K 0000		

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

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	AIM Number: 201293620 At this PSR survey, Briarcliff Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, all areas open to the corridor and hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 111 and had a census of 55 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 08/03/21			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have			

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	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)			
	1. Based on observation and interview, the facility failed to ensure 6 of 7 hazardous areas observed such as Storage rooms over 50 square feet, would latch in their frame and be provided with a self-closing device. This deficient practice could affect residents in the adjacent smoke compartment as well as staff on 100 vacant hall and Supply room. Findings include: Based on observations on 07/29/21 during the tour between 12:32 p.m. to 2:35 p.m. with the Maintenance Director (MD), the following areas were either not provided with corridor doors or were not equipped with a self-closing device: a. 100 vacant hall in room #4 stored 16 cardboard boxes and no corridor door was installed. b. 100 vacant hall in room #7 stored 25 cardboard	K 0321	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	10/25/2021

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	boxes and no corridor door was installed. c. 100 vacant hall in room #12 stored "too many to count" TMC cardboard boxes and no corridor door was installed. d. Central supply on 200 vacant Service hall stored 47 cardboard boxes in room #1 and no corridor door was installed. e. Central supply on 200 vacant Service hall stored 39 cardboard boxes in room #2 was not equipped with a closure on the corridor door. f. Supply room adjacent to dining room stored 21 cardboard boxes and was not equipped with a closure on the corridor door. Based on interview at the time of observations with the Administrator and MD it was stated the 100 hall and 200 hall were vacant and should not be subject to inspection and was not required to abide by LSC regulations. The Administrator further added the Supply room would have a self-closing device installed and also acknowledged the areas were over 50 square feet. This was discussed with the Administrator and MS during the exit conference. 3.1-19(b) This deficiency was cited on 06/03/21. The facility failed to implement a systemic plan of correction to prevent recurrence.		**practice:** No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken**: Residents will not be affected by the alleged deficient practice on the unpopulated area of facility. Residents on the memory unit have the potential to be affected by the closure on the Activity office door. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Observations: · a-e. These concerns are located on the 100 wing and 200 wing. These wings are not occupied and are designated for areas of future construction. Survey inspection noted that the walls constructed to separate the two wings from the temporary egress did not have a 2-hour rating required to maintain a separated area excluded from survey inspection. Facility contracted Brown and Brown Construction who modified these walls to meet the requirements for a 2-hour rated fire wall. CARMI Design Group architect designed the modifications and has reviewed finished construction for compliance. · f- The supply room noted is	

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			also located in the closed area referred to in observations a-e. This area was equipped with an automatic closure during original inspection and was noted by surveyor that door was equipped with self-closing device. This door continues to have an automatic closure device in place and proper operation was verified. · The Activity office that stores the hot oil popcorn popper was installed with an automatic closure. · Administrator audited storage rooms over 50 sq ft that stored any combustibles to ensure doors were installed with automatic closure devices. · Staff has been in-serviced on use on the popcorn popper only in rooms/areas protected with an automatic closure device and positive latching hardware. Activity staff have been in serviced on the proper storage areas for the hot oil popcorn popper. Administrator/designee will observe events featuring the use of the popcorn popper for proper use in a compliant area and that popcorn popper is stored in proper area after event. · Supervisors were educated on the safety of storing any combustible items in rooms with doors equipped with closure devices. · Maintenance Director/designee will observe storage areas to ensure areas over 50 sq. ft. that have	

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			combustibles in them are equipped with a functioning closure device and report findings monthly to the QAPI committee. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Audits will be completed 1x weekly for 4 weeks, then monthly for 2 months. Results of the audits will be reviewed by the QAPI committee for review and recommendations. **By what date the systemic changes will be completed:** 8/26/2021	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit 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.			

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	19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) 1. Based on observation and interview, the facility failed to ensure an automatic sprinkler system provided complete coverage in 2 of 2 areas observed. This deficient practice could affect only staff. Findings include: Based on observations on 07/29/21 during the tour between at 2:01 p.m. to 2:55 p.m. with the Administrator and Maintenance Director (MD), the following areas were not provided with sprinkler protection. a. The snow blower storage room. b. The enclosed area behind two gas dryers. Based on interview concurrent with the observations, the Administrator acknowledged items a and c were not provided with sprinkler protection. This was discussed with the Administrator during the exit conference. 3.1-19(b) This deficiency was cited on 06/03/21. The facility failed to implement a systemic plan of correction to prevent recurrence. 2. Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads was not obstructed in 1 of 1 Supply rooms 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 coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous	K 0351	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** All residents have the potential to be affected by these alleged deficiencies. **1.** · a. Outside storage area. Survey inspection noted that the area noted did not have the required forms to support that the wall connecting to the facility was verified to be of 2-hour fire rating	10/25/2021

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	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 3 residents, visitors and staff. Findings include: Based on observation on 07/29/21 at 2:02 p.m. with the Administrator and Maintenance Director (MD), in the Activities room on 700 hall there were assorted decorative items stored within 1/2 inch from the sprinkler head. Based on interview at the time of observation, the Administrator acknowledged the obstructions were less than eighteen inches from the sprinkler head. This was discussed with the Administrator during the exit conference. 3.1-19(b) This deficiency was cited on 06/03/21. The facility failed to implement a systemic plan of correction to prevent recurrence.		required to maintain a separated area excluded from survey inspection. A inspection hole was drilled through the adjoining wall for verification of construction material. CARMI Design Group architect inspected the observation access and verified that the adjoining wall does meet the requirements of a 2-hour fire wall. All other walls and ceiling of this room are concrete, and the room does not open into the facility. · b. The enclosed area behind the dryers has been removed giving all areas of the laundry room access to sprinklers. · Administrator will review contractor work upon completion for required compliance. · Maintenance Director/designee will continue monthly sprinkler inspections to ensure sprinkler heads are not obstructed. **2.** · Items in the Activities room on the 700 hall that were located less than 18” from sprinkler heads were immediately removed during original visit. On revisit, the surveyor did not inspect the 700-800 hallways due to an open house that was in progress. Areas were in compliance at time of revisit. · Staff have been re-educated on importance of keeping all areas clear 18” below the bottom of sprinklers. Signage has been installed in activity office and	

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			storage areas reminding all staff not to put any items above identified lines. · A temporary waiver has been submitted for the unoccupied storage area to allow the Review Plan time to be approved by the DSH engineer group. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · A Plan Review has been submitted for approval of the fire wall verification, project number 425216. · A temporary waiver has been submitted to allow the Plan Review to be reviewed by the DHS engineer department. · The Administrator/designee will audit activity office and storage areas for compliance of no items being stored within 18" from the bottom of sprinklers 2x week for 4 weeks and 1x week for 8 weeks to ensure compliance. Sprinkler head monitoring will be ongoing. Results of inspections will be presented to the QAPI" committee in scheduled Maintenance QAPI reports. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Results of the Life Safety Survey will be presented to	

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			and reviewed by the QAPI committee. The QAPI committee will be informed on the Plan Review progression and approval. Maintenance Director/ Designee will report any findings of non-compliance in storage rooms to the QAPI committee for review/recommendations. **By what date the systemic changes will be completed:** 8/26/2021	
K 0372 SS=E 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 8 of 8 smoke barriers observed had a minimum of a 1/2 hour fire resistive rating and the penetrations caused by the passage of wire and/or conduit the smoke barrier walls was protected to maintain the smoke resistance of each smoke barrier. LSC 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. This	K 0372	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared*	08/26/2021

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	deficient practice could affect 12 residents, visitors and staff. Findings include: Based on observations on 07/29/21 during the tour between 2:04 p.m. to 2:30 p.m. with the Administrator and Maintenance Director (MD), the following areas had penetrations in smoke barriers which were not sealed or improperly sealed with foam: a. Yellow foam used to seal around four conduits penetrating block walls in Laundry located in the basement. b. Basement corridor next to Electric room had numerous conduits penetrating block wall and orange foam was used to seal around penetrations. c. Electric room in basement there were numerous conduits penetrating the block wall and yellow foam was used to seal around penetrations. d. At least thirteen areas in the Basement storage area had conduits of various diameters penetrating the block walls and yellow and orange foam was used to seal around penetrations. e. Storage room, across from room #507 used foam to seal around HVAC ductwork. f. Smokewall next to Therapy used foam to seal around HVAC ductwork on East side of wall. g. Smokewall on 400 hall next to Nursing station, had a large pipe penetrating wall and the gap was not sealed. h. Service corridor smokewall used orange foam to seal around a one inch diameter conduit at the top of the wall and to the right there was TMC wires penetrating the wall and a bright yellow foam was used to seal the opening. Based on interview concurrent with each observation with the Administrator and MD, items		*and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. a-h. Brown and Brown construction has been contracted to correct the penetrations noted. Administrator/designee will inspect the noted areas for compliance upon contractor completion. Maintenance Director will audit any areas that new construction/ repairs are completed in the building for penetration compliance, this will remain on-going. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Director/designee will inspect any contractor work that involves penetrating any smoke barriers for proper sealing of new penetrations. Results of	

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	a through h were all confirmed. This was discussed with the Administrator during the exit conference. 3.1-19(b) This deficiency was cited on 06/03/21. The facility failed to implement a systemic plan of correction to prevent recurrence.		repairs/corrections of smoke barrier penetrations will be reported to the QAPI committee. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Any new construction, repairs, and/or maintenance that involves penetration of a smoke wall will be inspected and corrected if required for compliance. The QAPI committee will review reports for any further recommendations. **By what date the systemic changes will be completed:** 8/26/2021	
K 0511 SS=F 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 1 areas observed, protected electrical wiring according to NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect only staff. Findings include:	K 0511	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The*	10/25/2021

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	Based on observation on 07/29/21 at 2:16 p.m. with the Administrator and Maintenance Director (MD), there were exposed electrical wires jutting out of a metal conduit next to the staff desk on vacant 200 hall. Based on interview at the time of observation, the MD acknowledged the exposed wires were not confined in an electrical junction box with a cover plate. This finding was discussed with the Administrator during the exit conference. 3.1-19(b) This deficiency was cited on 06/03/21. The facility failed to implement a systemic plan of correction to prevent recurrence. 2. Based on observation and interview, the facility failed to ensure 1 of 9 corridors with electrical circuit panels were secured from non-authorized personnel per LSC 19.5.1.1. LSC 19.5.1.1 states utilities shall comply with the provisions of Section 9.1. LSC 9.1.2 states electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70 Section 110.27(A) states live parts of electrical equipment over 50 volts or more shall be guarded against accidental contact by approved closures or by any of the following means: (1) by location in a room, vault, or similar enclosure that is accessible only to qualified persons. This deficient practice could affect any residents, visitors and staff exiting 100 vacant hall. Findings include: Based on observation on 07/29/21 at 2:40 p.m. with the Administrator and Maintenance Director (MD) there were two electrical circuit panels		*plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. a-h. Brown and Brown construction has been contracted to correct the penetrations noted. Administrator/designee will inspect the noted areas for compliance upon contractor completion. Maintenance Director will audit any areas that new construction/ repairs are completed in the building for penetration compliance, this will remain on-going. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Director/designee will inspect any contractor work that involves penetrating any smoke barriers for proper sealing	

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	155831	A. BUILDING 01 B. WING	07/29/2021

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	installed in the corridor wall on 100 vacant hall which were not secured against non-authorized personnel. Based on interview during the observation, the MD confirmed the electrical panels were unsecured and could be opened by anyone and thought since they were on a vacant hall it would not matter. This was discussed with the Administrator during the exit conference. 3.1-19(b) This deficiency was cited on 06/03/21. The facility failed to implement a systemic plan of correction to prevent recurrence.		of new penetrations. Results of repairs/corrections of smoke barrier penetrations will be reported to the QAPI committee. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Any new construction, repairs, and/or maintenance that involves penetration of a smoke wall will be inspected and corrected if required for compliance. The QAPI committee will review reports for any further recommendations. **By what date the systemic changes will be completed:** 8/26/2021	
K 0521 SS=F 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. 18.5.2.1, 19.5.2.1, 9.2 Based on record review and observation, the facility failed to ensure at least 4 of 4 smoke/fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90 A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90 A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90 A, 2012 Edition, Section 5.4.8.1 states fire dampers shall	K 0521	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared*	08/26/2021

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	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 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 occupants. Findings include: Based on record review on 07/29/21 at 2:15 p.m. with the Maintenance Director (MD), under the Fire Damper section of the Fire Safety log book there was a single sheet of writing paper with the words "Done 09/20/20", no other information was given as to the location, condition or inspection. Based on interview concurrent with record review, the MD stated that was the doing of the previous Maintenance Director. This was discussed with the Administrator during the exit conference. 3.1-19(b) This deficiency was cited on 06/03/21. The facility failed to implement a systemic plan of correction to prevent recurrence.		*and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**: No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** No residents have the potential to be affected by this citation, citation was written in error. Supporting documentation notes that facility was cited this in error. Facility requests that this citation be removed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**: · Vendor was contacted to inspect fire dampers as no records of inspection were on record. Vendor inspected and left report that shows this facility does not have any fire dampers. · Report shows that citation was written in error. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put into place: No follow up is required for this citation as facility was in compliance. **By what date the systemic changes will be completed:** 8/26/2021	
K 0531 SS=E Bldg. 01	NFPA 101 Elevators Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 Based on observation, interview, and record review; the facility failed to ensure the elevator equipment in 1 of 1 elevator equipment rooms was provided with a shunt trip. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there	K 0531	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or*	08/26/2021

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	is a means for disconnecting the main power supply to the affected elevator automatically upon, or prior to, the application of water from the sprinkler located in the elevator machine room. The elevator equipment room was located in the basement and could affect any resident using the elevator as well as visitors and staff. Findings include: Based on observation and interview on 07/29/21 at 2:32 p.m. with the Maintenance Director (MD), the elevator equipment room located in the basement was provided with a sprinkler head and smoke detector protection, however a shunt trip could not be located. The MD and Administrator acknowledged they did not know what a shunt trip is and did not know if the elevator machine room was equipped with one. This was discussed with the Administrator during the exit conference. 3.1-19(b) This deficiency was cited on 06/03/21. The facility failed to implement a systemic plan of correction to prevent recurrence.		*conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken**: This deficient practice could affect staff; elevator is for service staff only. Electrical contractor inspected the elevator system and verified that elevator is already equipped with an elevator shunt. No further corrections are needed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Contractor showed Administrator and Maintenance Director how the system works and all the parts to verify that a shunt system is in place. Pictures were taken to verify the shunt system is in place. No audits are required. **How the corrective action(s) will be monitored to ensure the**	

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			deficient practice will not recur, i.e., what quality assurance program will be put into place: No further action is required as elevator was properly equipped with a shunt system and cited in error. **By what date the systemic changes will be completed:** 8/26/2021	
K 0761 SS=F Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 5 of 5 fire door assemblies were completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected 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, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to	K 0761	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be**	08/25/2021

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	testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all occupants. Findings include: Based on record review on 07/29/21 at 2:30 p.m. with the Maintenance Director (MD), the last		**taken:** All residents and staff in the facility have the potential to be affected by this alleged deficient practice. The Maintenance Director has added the fire rating tag inspection to the annual door inspection log. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A current inspection of fire doors was completed by the Maintenance Director from The Milton Home, knowledgeable inspector in this field. The documentation of inspection was placed in Life Safety binder for reference. Results of this inspection will be presented to the QAPI committee for review/recommendation of inspection. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The QAPI committee will review the citation and the revised inspection documentation for compliance. The next annual inspection will be placed the TELS maintenance reporting system as a recurring inspection. **By what date the systemic changes will be completed:** 8/26/2021	

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	annual fire door assembly inspection available for review was simply written on one sheet of writing paper and stated "done 09/20/20". Based on interview at the time of record review, the MD stated the last fire door annual inspection was conducted by the last Maintenance Director. This finding was discussed with the Administrator during the exit conference. 3.1-19(b) This deficiency was cited on 06/03/21. The facility failed to implement a systemic plan of correction to prevent recurrence.			