STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155573	A. BUILDING -- B. WING	08/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	981 BEECHWOOD AVE MIDDLETOWN, IN 47356

(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: 08/16/22 Facility Number: 000342 Provider Number: 155573 AIM Number: 100289140 At this Emergency Preparedness survey, Miller's Merry Manor was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 60 certified beds. At the time of the survey, the census was 19. Quality Review completed on 08/17/22	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: 08/16/22 Facility Number: 000342 Provider Number: 155573 AIM Number: 100289140 At this Life Safety Code survey, Miller's Merry Manor was found not in compliance with	K 0000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155573	A. BUILDING 01 B. WING	08/16/2022

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 60 and had a census of 19 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had a detached wooden storage building which was not sprinkled. Quality Review completed on 08/17/22			
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC	K 0345	To immediately correct the problem, the previously identified failed smoke detectors (via	09/16/2022

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	9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, Section 14.4.5.3.1 states smoke detector sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states smoke detector sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with Section 14.4.5.3.3. This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Administrator and Director of Maintenance on 08/16/22 between 10:15 a.m. and 12:30 p.m., the fire alarm report dated 10/11/21 stated that 4 smoke detectors failed the sensitivity test and needed to be replaced. No documentation was available for review indicating replacement of the failed appliances. The Director of Maintenance sought additional paperwork from the facilities contractor during the survey, but by the end of the survey, not other documentation was provided. The finding was reviewed with the Director of Maintenance at the time of discovery and again during the exit conference with the Administrator at 2:15 p.m. 3.1-19(b)		sensitivity testing) were replaced. All residents had the potential to be affected by the deficient practices. Replacement of the failed smoke detectors as described above protected all residents. To ensure the deficient practice does not recur, the administrator and the Maintenance Director were educated on LSC 9.6.1.3 (NFPA 70 & 72). Additionally, a system was initiated where work orders for external vendors will now be part of the existing internal work order system. In doing so, a log will be kept, and items will not be removed until work is completed by external vendors. To monitor and ensure the deficient practice does not recur, a Quality Assurance tool titled: "LSC Survey POC 2022" (Attachment A) was implemented. This tool will be completed 5x per week for four weeks, weekly for four weeks, and monthly thereafter until it is reviewed by the QAPI team and a determination made for appropriate ongoing use. All systemic changes will be made by 9/16/22.	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service			

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	Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on record review and interview with the Administrator and Director of Maintenance on 08/16/22 between 10:15 a.m. and 12:30 p.m., the fire watch plan failed to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Administrator acknowledged the fire watch documentation provided stated to contact the Indiana State Department of Health via the ISDH Gateway link but not at the e-mail address listed above. The finding was reviewed with the Administrator at the time of discovery and again during the exit conference with the Administrator at 2:15 p.m.	K 0346	*An Informal Dispute Resolution **(IDR)** request has been made as the facility does not agree with the alleged citation received during the survey. However, as required by ISDH, even when the facility disagrees with a finding, a Plan of Correction must be made and submitted. Please see the required POC below: To immediately correct the problem, the Fire Watch Policy (Attachment B) was modified to include contacting the Indiana State Department of Health Via the ISDH Gateway Link at https://gateway.isdh.in.gov as the primary method or by the secondary method when ISDH Gateway is non-operational by completing the Incident Reporting form and emailing it to incidents @ ISDH.in.gov All residents had the potential to be affected by the deficient practices. Changes to the Fire Watch Policy (Attachment B), as outlined above, protect all residents from the alleged deficient practice. To ensure the alleged deficient	09/16/2022

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	3.1-19(b)		practice does not recur, the administrator and the Maintenance Director were educated on LSC 9.6.1.6. To monitor and ensure the deficient practice does not recur, a Quality Assurance tool titled: "LSC Survey POC 2022" (Attachment A) was implemented. This tool will be completed 5x per week for four weeks, weekly for four weeks, and monthly thereafter until it is reviewed by the QAPI team and a determination made for appropriate ongoing use. All systemic changes will be made by 9/16/22.	
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 _____ 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			

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	Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observation during a tour of the facility and interview with the Director of Maintenance on 08/16/22 between 12:30 p.m. and 2:15 p.m., there was one spare sprinkler cabinet in the riser room that included 12 spare sprinklers; 6 of which were not in their own protected slot. They were stored loose in the cabinet and not secured in holders. Additionally, 3 of the 12 spare sprinklers were used, showing obvious signs of previous installation. Based on interview at the time of the observation, the Director of Maintenance agreed the spare sprinkler cabinet had spare sprinklers not in protected slots and some of the spares appeared to be previously used. The finding was reviewed with the Director of Maintenance at the time of discovery and again	K 0353	To immediately correct the problem, a new cabinet was ordered to store the sprinkler heads. The sprinkler heads are hanging and secured in the cabinet and not loose within the cabinet, but each is placed in their "Own Holders" within the cabinet. Additionally, 2 new (not previously used) sprinkler heads for each sprinkler type in the facility were ordered and are in place as described above in the sprinkler cabinet. The previously used sprinkler heads were removed. All residents had the potential to be affected by the deficient practices. The new cabinet and sprinkler heads placed, as described above, will prevent the alleged deficient practice from affecting other residents. To ensure the alleged deficient practice does not recur, the administrator and the Maintenance Director were educated on NFPA 25 Section 5.4.1.4. To monitor and ensure the deficient practice does not recur, a Quality Assurance tool titled: "LSC Survey POC 2022" (Attachment A) was implemented. This tool will be completed 5x per week for four weeks, weekly for four weeks, and monthly thereafter until it is reviewed by the QAPI team and a determination made for appropriate ongoing use. All systemic changes will be	09/16/2022

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	during the exit conference with the Administrator at 2:15 p.m. 3.1-19(b)		made by 9/16/22.	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide 1 of 1 correct written policy in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person	K 0354	*An Informal Dispute Resolution **(IDR)** request has been made as the facility does not agree with the alleged citation received during the survey. However, as required by ISDH, even when the facility disagrees with a finding, a Plan of Correction must be made and submitted. Please see the required POC below: To immediately correct the problem, the Fire Watch Policy (Attachment B) was modified to include contacting the Indiana State Department of Health Via the ISDH Gateway Link at https://gateway.isdh.in.gov as the	09/16/2022

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	should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on record review and interview with the Administrator and Director of Maintenance on 08/16/22 between 10:15 a.m. and 12:30 p.m., the fire watch plan failed to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Administrator acknowledged the fire watch documentation provided stated to contact the Indiana State Department of Health via the ISDH Gateway link but not at the e-mail address listed above. The finding was reviewed with the Administrator at the time of discovery and again during the exit conference with the Administrator at 2:15 p.m. 3.1-19(b)		primary method or by the secondary method when ISDH Gateway is non-operational by completing the Incident Reporting form and emailing it to incidents @ ISDH.in.gov All residents had the potential to be affected by the deficient practices. Changes to the Fire Watch Policy (Attachment B), as outlined above, protect all residents from the alleged deficient practice. To ensure the alleged deficient practice does not recur, the administrator and the Maintenance Director were educated on LSC 9.6.1.6. To monitor and ensure the deficient practice does not recur, a Quality Assurance tool titled: "LSC Survey POC 2022" (Attachment A) was implemented. This tool will be completed 5x per week for four weeks, weekly for four weeks, and monthly thereafter until it is reviewed by the QAPI team and a determination made for appropriate ongoing use. All systemic changes will be made by 9/1/22.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch			

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	solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure all corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke.	K 0363	To immediately correct the problem, the Resident Room #26, HK Supply Closet near employee entrance, Dietary Supply Room,	09/16/2022

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	This deficient practice could affect 6 staff and 15 residents. Findings include: Based on observation during a tour of the facility and interview with the Director of Maintenance on 08/16/22 between 12:30 p.m. and 2:15 p.m., the following corridor doors failed to latch positively into their respective door frames: a) Resident Room #26 b) Housekeeping Supply Closet near the employee entrance, equipped with a self-closing device. c) Dietary Supply Room near the employee entrance, equipped with a self-closing device. d) Mop Supply Closet in the Kitchen, equipped with a self-closing device. e) Kitchen door into the dining room. equipped with a self-closing device. f) Kitchen door into the Dietary Supply room, equipped with a self-closing device. The finding was reviewed with the Director of Maintenance at the time of discovery and again during the exit conference with the Administrator at 2:15 p.m. 3.1-19(b)		Mops Supply Closet, Kitchen/Dining room door, door all had adjustments made to the door, and the closures to ensure the doors close in accordance with NFPA 19.3.6.3. Additionally, an air analysis was performed via a heating and air vendor to assist with adjusting negative pressure that could contribute to the proper closure of the doors. The Kitchen/supply room door is being special built and will be replaced on 9/16/22 to ensure the door closes in accordance with NFPA 19.3.6.3. All residents had the potential to be affected by the deficient practices. Adjustment and replacement of the doors as outlined above, protect all residents from the alleged deficient practice. To ensure the alleged deficient practice does not recur, the Maintenance Director was educated on NFPA 19.3.6.3. To monitor and ensure the deficient practice does not recur, a Quality Assurance tool titled: "LSC Survey POC 2022" (Attachment A) was implemented. This tool will be completed 5x per week for four weeks, weekly for four weeks, and monthly thereafter until it is reviewed by the QAPI team and a determination made for appropriate ongoing use. All systemic changes will be	

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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 Based on observation and interview, the facility failed to ensure 1 of over 10 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance	K 0511	To immediately correct the problem, a GFCI outlet was installed and replaced the previous electric receptacle used to power the ice machine. All residents had the potential to be affected by the deficient practices. Replacement of the receptacle, as outlined above, protects all residents from the alleged deficient practice. To ensure the alleged deficient practice does not recur, the Maintenance Director was educated on LSC 19.1.2 and NFPA 70 NEC 210.8. To monitor and ensure the deficient practice does not recur, a Quality Assurance tool titled: "LSC Survey POC 2022" (Attachment A) was implemented. This tool will be completed 5x per week for four weeks, weekly for four weeks, and monthly thereafter until it is reviewed by the QAPI team and a determination made for appropriate ongoing use.	09/16/2022

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MILLER'S MERRY MANOR	981 BEECHWOOD AVE MIDDLETOWN, IN 47356

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	with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff and up to 4 residents while at the ice machine. Findings include:		All systemic changes will be made by 9/16/22.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155573	A. BUILDING 01 B. WING	08/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	981 BEECHWOOD AVE MIDDLETOWN, IN 47356

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	Based on observation during a tour of the facility and interview with the Director of Maintenance on 08/16/22 between 12:30 p.m. and 2:15 p.m., the ice machine near the employee entrance was connected to an electric receptacle which was being used to power the freestanding ice machine, with it's own water supply. The ice machine was located within 3 feet of the electric receptacle, and not provided with ground fault circuit interruption (GFCI). The Administrator at the time of observation stated she did not believe the receptacle was on a GFCI circuit. The finding was reviewed with the Administrator at the time of discovery and again during the exit conference with the Administrator at 2:15 p.m. 3.1-19(b)			
K 0761 SS=E Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of at least 1 fire door assembly was completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire	K 0761	To immediately correct the problem, the an inspection was completed of the Oxygen Transfilling room door. All residents had the potential to be affected by the deficient practices. Inspection of the Oxygen Transfer room door protects all residents from the deficiency. To ensure the alleged deficient practice does not recur, the Maintenance Director was educated on NFPA 80, 5.2.1. Additionally, a complete facility review was conducted with the assigned inspector and the Maintenance Director to ensure all	09/16/2022

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	door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both 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 6 residents. Findings include: Based on record review and interview with the Administrator and Director of Maintenance on		doors that required inspection were maintained on the list of doors requiring inspection. To monitor and ensure the deficient practice does not recur, a Quality Assurance tool titled: "LSC Survey POC 2022" (Attachment A) was implemented. This tool will be completed 5x per week for four weeks, weekly for four weeks, and monthly thereafter until it is reviewed by the QAPI team and a determination made for appropriate ongoing use. All systemic changes will be made by 9/16/22.	

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	08/16/22 between 10:15 a.m. and 12:30 p.m., no documentation of an annual inspection for the fire door assembly at the Oxygen Transfilling room was available for review. Based on observation during the tour the Oxygen Transfilling room has one fire door assembly. Based on interview at the time of records review and observation, the Director of Maintenance stated the annual fire door inspection was not completed within the last year and was previously unaware a fire door inspection was needed on the Transfilling Room door. No documentation was available reflecting a door inspection prior to January 2020 and the beginning of the 1135 COVID waiver. The finding was reviewed with the Director of Maintenance at the time of discovery and again during the exit conference with the Administrator at 2:15 p.m. 3.1-19(b)			