STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING -- B. WING	08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE KOKOMO	3518 S LAFOUNTAIN ST KOKOMO, IN 46902

(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 Dates: 08/16/23, 08/17/23, and 08/18/23 Facility Number: 000025 Provider Number: 155064 AIM Number: 100274850 At this Emergency Preparedness survey, Aprion Care Kokomo was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 105 certified beds. At the time of the survey, the census was 73. Quality Review completed on 08/28/23	E 0000	This Plan of Correction is the center's credible allegation of compliance. *Preparation and/or execution of this plan of correction does not constitute admission or agreement of 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.*	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paula Carroll	Administrator	09/11/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in	E 0004	I. What corrective action(s) will be accomplished for those residents found to have	09/15/2023

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	accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and the Administrator on 08/16/23 at 2:00 p.m., the review and updated signature form showed last review and updated was completed in 2019, no other documentation could be found to show the EPP was reviewed and updated within the last year. Also, the EEP contained new and old policies with conflicting information. Based on an interview during records review, the Administrator and Maintenance Director stated the documentation to show the EEP has been reviewed or updated within the last year could not be found. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference on 08/18/23 at 1:00 p.m.		been affected by the deficient practice. No residents were affected by this alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by this alleged deficient practice. The IDT reviewed and updated the complete emergency program. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The IDT was in serviced on the emergency management requirements. A complete review of the emergency plan was added to the QAPI calendar every 12 months. IV. 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 admin or designee will review the QAPI calendar monthly and check the date of the last update of the emergency preparedness plan to ensure it is reviewed at least every 12 months. The results	

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			of these audits will be reviewed in Quality Assurance Meeting monthly x12 months or until an average of 100% compliance is achieved x12 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at			

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	paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters			

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	likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and the Administrator on 08/16/23 at 2:00 p.m., the review and updated signature form showed last review and updated was completed in 2019, no other documentation could be found to show the EPP Policies and Procedures were reviewed and updated within the last year. Also, the EEP Policies and Procedures contained new and old policies with conflicting information. Based on an interview during records review, the Administrator and Maintenance Director stated the documentation to show the EEP Policies and Procedures were reviewed or updated within the last year could not be found. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference on 08/18/23 at 1:00 p.m.	E 0013	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by this alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by this alleged deficient practice. The emergency preparedness policies and procedures were reviewed and updated. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The IDT was in serviced on the emergency management requirements. A review and update of the emergency preparedness policies and procedures was added to the QAPI calendar every 12 months. IV. How the corrective action(s) will be monitored to	09/15/2023

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			ensure the deficient practice will not recur i.e., what quality assurance program will be put into place. The admin or designee will review the QAPI calendar monthly and also check the date of the last update of the emergency preparedness policies and procedures to ensure it is reviewed at least every 12 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x12 months or until an average of 100% compliance is achieved x12 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
E 0015 SS=F Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1) Subsistence Needs for Staff and Patients §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years			

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	[annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems.			

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	(C) Sewage and waste disposal. Based on record review and interview, the facility failed to ensure Emergency Preparedness Plan (EPP) subsistence needs policies and procedures did not have conflicting policies. At a minimum the plan shall include, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 08/17/23 at 10:50 a.m., in the EPP binder the subsistence needs documentation for the emergency preparedness program had conflicting policies. The EPP documentation for extreme temperatures and for the provision of subsistence needs for food and water had two different and conflicting policies. Based on interview at the time of records review, the Administrator stated there are two conflicting policies in the EPP binder and all old policies will be removed from the EPP. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference on 08/18/23 at 1:00 p.m.	E 0015	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by this alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by this alleged deficient practice. The subsistence needs and minimum temperature policy were both updated in all binders. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. All policies were reviewed to ensure they are the most updated version, and no conflicting information remains in the binders. IV. 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 emergency preparedness policies will be reviewed quarterly to ensure they are up to date and no conflicting policies are in place.	09/15/2023

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			The results of these audits will be reviewed in Quality Assurance Meeting quarterly for 1 year. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
E 0020 SS=F Bldg. --	403.748(b)(3), 416.54(b)(2), 418.113(b)(6)(ii), 441.184(b)(3), 482.15(b)(3), 483.475(b)(3), 483.73(b)(3), 485.625(b)(3), 485.68(b)(1), 485.727(b)(1), 485.920(b)(2), 491.12(b)(1), 494.62(b)(2) Policies for Evac. and Primary/Alt. Comm. §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and			

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	alternate means of communication with external sources of assistance. *[For RNHCIs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients.			
	Based on record review and interview, the facility failed to ensure Emergency Preparedness Plan (EPP) include non-conflicting information for safe evacuation from the LTC facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication	E 0020	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice II. How other residents having the	09/15/2023

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	with external sources of assistance in accordance with 42 CFR 483.73(b) (3). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator on 08/17/23 at 10:37 a.m., the provided EPP binder had two evacuation policies with conflicting information. Based on interview at the time of records review, the Administrator stated there are two conflicting policies in the EPP binder and all old policies will be removed from the EPP. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference on 08/18/23 at 1:00 p.m.		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. The evacuation policy was updated in all binders. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All policies were reviewed to ensure they are the most updated version, and no conflicting information remains in the binders. IV. 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 emergency preparedness policies will be reviewed quarterly to ensure they are up to date and no conflicting policies are in place. The results of these audits will be reviewed in Quality Assurance Meeting quarterly for 1 year. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c),			

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	485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Communication program at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and the Administrator on 08/16/23 at 2:00 p.m., the review and updated signature form showed last review and updated was completed in 2019, no other documentation could be found to show the EPP Communication program was reviewed and updated within the last year. Also, the EEP Communication program contained new and old policies with conflicting information. Based on an interview during records review, the Administrator and Maintenance Director stated the documentation to show the EEP Communication program has been reviewed or updated within the last year could not be found.	E 0029	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. The entire emergency plan was reviewed and updated by the IDT. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The IDT was in serviced on the emergency preparedness	09/15/2023

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	155064	A. BUILDING -- B. WING	08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			requirements. A complete review of the emergency plan was added to the QAPI calendar every 12 months. IV. 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 admin or designee will review the QAPI calendar monthly and also check the date of the last update of the emergency preparedness plan to ensure it is reviewed at least every 12 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x12 months or until an average of 100% compliance is achieved x12 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).			

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	*[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the			

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	communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.			
	Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Training and Testing program at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and the Administrator on 08/16/23 at 2:00 p.m., the review and updated signature form showed last review and updated was completed in 2019, no other documentation could be found to show the EPP Training and Testing program was reviewed and updated within the last year. Also, the EEP Training and Testing program contained new and old policies with conflicting information. Based on an interview during records review, the Administrator and Maintenance Director stated	E 0036	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. The emergency preparedness training plan was reviewed and updated by the IDT. III. What measures will be put into place and what systemic changes	09/15/2023

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	the documentation to show the EEP Training and Testing program has been reviewed or updated within the last year could not be found. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference on 08/18/23 at 1:00 p.m.,		will be made to ensure that the deficient practice does not recur; The IDT was in serviced on the emergency preparedness requirements. A complete review of the emergency preparedness training plan was added to the QAPI calendar every 12 months. IV. 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 admin or designee will review the QAPI calendar monthly and also check the date of the last update of the emergency preparedness plan to ensure it is reviewed at least every 12 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x12 months or until an average of 100% compliance is achieved x12 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1),			

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	§485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice			

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	employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training			

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	at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's			

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	emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain			

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	documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Administrator and the Maintenance Director on 08/16/23 at 1:11 p.m. and on 08/18/23 at 12:20 p.m., no documentation of annual EEP training and no documentation to show staff could demonstrate knowledge of the EPP was available for review. Based on an interview at the time of records review, the Maintenance Director and the Administrator stated the EPP training was conducted during an in-service, but the documentation could not be located. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference on 08/18/23 at 1:00 p.m.	E 0037	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. All staff will complete emergency preparedness training. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff were trained on the updated emergency preparedness plan including the risk assessment and policies and procedures. The facility will conduct annual staff training on the emergency preparedness plan the month after the IDT completes the annual review. Emergency preparedness training was added to new employee orientation. If a significate change is made to the emergency preparedness plan a staff training will be scheduled to	09/15/2023

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			review the changes. IV. 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 administrator or designee will audit the in-service sign in sheet annually to ensure all staff have been in serviced the month after the annual IDT review. The admin or designee will review all new employee files monthly to ensure training has occurred. If significate changes are made to the plan the admin or designee will audit to ensure a training of the changes occurred. The results of these audits will be reviewed in Quality Assurance Meeting annually. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems.			

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	The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the			

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	Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING -- B. WING	08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE KOKOMO	3518 S LAFOUNTAIN ST KOKOMO, IN 46902

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	(xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and the Administrator on 8/16/23 at 11:00 a.m. and on 08/18/23 at 12:40 p.m., the generator powered by natural gas was missing required information for monthly load testing and a natural gas reliability letter required by LSC and NFPA 110. Based on interview on 08/18/23 at 12:50 p.m., the Maintenance Director stated the generator was missing some of the required documentation. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference on 08/18/23 at 1:00 p.m.	E 0041	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. A monthly generator run was completed, and a letter of reliability was obtained from the natural gas company. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director was in serviced on the monthly generator run requirements. IV. 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 administrator or designee will audit the monthly generator run log	09/15/2023

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			monthly to ensure it is completed monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
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) which resulted in Immediate Jeopardy. Immediate Jeopardy was cited at K711 on 08/16/23 and removed on 08/18/23. Survey Dates: 08/16/23, 08/17/23, and 08/18/23 Facility Number: 000025 Provider Number: 155064 AIM Number: 100274850 At this Life Safety Code survey, Aperion Care Kokomo 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	K 0000	This Plan of Correction is the center's credible allegation of compliance. *Preparation and/or execution of this plan of correction does not constitute admission or agreement of 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.*	

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	Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated detectors in all resident sleeping rooms. The facility has a capacity of 105 and had a census of 73 at the time of this survey. All areas where the residents have customary access were sprinklered. Quality Review completed on 08/28/23			
K 0100 SS=F Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. #1.) Based on observation and interview, the facility failed to maintain latching hardware on 3 of 8 smoke barrier doors. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect staff and up to 30 residents. Findings include: Based on observation with the Maintenance Director on 08/16/23 between 01:45 p.m. and 02:35 p.m., the set of smoke barrier doors to the South Magnolia Hall, North Magnolia Hall and by the Front Hall were provided with latching hardware but failed to close and latch when tested. Based on interview at the time of observation, the	K 0100	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 30 residents had the potential to be affected by this alleged deficient practice. The door latches that did not latch will be adjusted or replaced. All PTAC until filters will	09/15/2023

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	Maintenance Director agreed the smoke doors were equipped with latching devices, but the doors did not properly close and latch when tested. #2.). Based on observation, records review, and interview, the facility failed to ensure at least 50 of 50 Packaged Terminal Air Conditioner (PTAC) were maintained in a safe operational condition. 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 all residents in the facility. Findings include: Based on observation with the Maintenance Director on 08/16/23 between 02:30 p.m. and 03:30 p.m., the PTACs throughout the building had dirty or clogged air filters. This condition blocks air from entering the unit causing the PTACs to run harder and can lead to overheating of the plug resulting in a fire. Based on records review, there was no documentation to show the last time the PTAC units were cleaned and did not have a copy of the PTAC Manual to show manufacturer's recommendations for maintenance for all PTACs. Based on interview at the time of observations and records review, the Maintenance Director agreed the PTAC's filters were dirty. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference on 08/18/23 at 01:00 p.m.		be cleaned or replaced. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All door latches will be tested weekly to ensure they latch properly. the results of the test will be recorded on door latch log. Any door not properly latching will be repaired. All PTAC units will be inspected monthly for proper function and preventive maintenance and the results tracked on the preventive maintenance log. IV. 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 admin or designee will audit the door latch log weekly to ensure all doors latch properly or are repaired timely. The admin or designee will audit the PTAC preventive maintenance log weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	3.1-19(b)			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4			

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	DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure 2 of 10 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be	K 0222	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 49 residents had the potential to be	09/15/2023

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	continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect 49 residents on Harmony Hall and by the front enterance. Findings include: A.) Based on observation during a tour of the facility with the Maintenance Director on 08/16/23 at 01:40 p.m. the Harmony Hall exit door was equipped with a 15 second delayed egress. When the exit door was tested the irreversible process to release the lock was not initiated. Based on interview at the time of observation, the Maintenance Director tried 3 times to activate the delay egress and stated the delayed egress is not working and will need to be repaired. B,) Based on observations during tour of the facility with the Maintenance Director on 08/16/23 at 1:00 p.m., the double door exit located in Main Entrance was provided with delayed egress locks but lacked the proper signage indicating the doors can be opened in 15 seconds by pushing on the door. Based on interview at the time of observation, the Maintenance Director acknowledged the door was equipped with a delayed egress and lacked the proper signage. This finding was reviewed with the Administrator and Maintenance Director at the exit conference on 08/18/23 at 01:00 p.m. 3.1-19(b)		affected by this alleged deficient practice. The delayed egress will be repaired on the harmony hall exit door and a delayed egress sign will be added to the main exit door. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director will test exit doors delayed egress daily to ensure proper function and they delayed egress sign remains in place and record the results on the preventative maintenance log. IV. 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 administrator or designee will audit preventative maintenance log weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review and interview the facility failed to ensure the preventative maintenance for 50 of 50 battery operated smoke alarms in resident rooms was conducted according to manufacturer's published instructions. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents. Findings include: Based on records review with the with the Maintenance Director and the Administrator on 08/16/23 at 12:42 p.m., the "Battery-Operated Smoke Detector Maintenance Log" showed monthly testing of the battery-operated smoke alarms. The manufacturer's published instructions for the smoke alarms stated: the alarms require weekly testing. Based on interview on 08/18/23 at 12:50 p.m., the Maintenance Director stated the alarms are tested monthly, and agreed the alarms should be tested weekly according to	K 0300	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. All battery-operated smoke alarms were tested for proper function. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The battery-operated smoke alarm testing was changed from monthly to weekly. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance	09/15/2023

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	manufacturer's published instructions. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference on 08/18/23 at 1:00 p.m. 3.1-19(b)		program will be put into place; The administrator will audit the battery-operated smoke alarm testing log weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
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 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			

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	b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of 1 storage rooms with large amounts of combustible storage and greater than 50 square feet was protected as a hazardous area. This deficient practice could affect 10 residents in the area. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 08/16/23 at 01:35 p.m., storage room #129 contained over 20 boxes of supplies and was greater than 50 square feet making this a hazardous area. The storage room was not protected as a hazardous area because the corridor door to the room was not self-closing or automatic closing. Based on interview at the time of observation, the Maintenance Director agreed the storage room contained large amount of combustible storage, was larger than 50 square feet, and the corridor door to the room was not self-closing. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference on 08/18/23 at 01:00 p.m.. 3.1-19(b)	K 0321	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by this alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. All doors on rooms considered hazardous areas were audited for a self-closing device. a self-closing device was added to the storage room 129. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A weekly inspection of doors on all rooms considered a hazardous area was added to the preventive maintenance log.	09/15/2023

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			IV. 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 administrator or designee will audit the weekly door inspection on the maintenance log monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
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 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			

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	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 staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchen. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect staff in the kitchen and 25 residents in the dining room. Findings include: Based on observation with the Maintenance Director on 08/16/23 at 02:15 p.m., the kitchen contained a UL 300 hood system and a K-class fire extinguisher with posted instructions. Based on interview, the Cook was asked; what is the correct response if there was a grease fire underneath the hood. The employee replied; just tell me so I get it right. The employee failed to indicate activating the UL 300 hood extinguishing system and using the correct fire extinguisher for a hood grease fire. The Maintenance Director acknowledged the Cooks response and educated the cook on the proper procedure. This finding was reviewed with the Administrator and MD at the Maintenance Director conference on 08/18/23 at 01:00 p.m.. 3.1-19(b)	K 0324	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 25 residents have the potential to be affected by this alleged deficient practice. All kitchen staff were in serviced on the use of the UL 300 hood and K class fire extinguishers. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Kitchen staff will be in serviced upon hire and quarterly on the use of kitchen fire suppression equipment. IV. 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; Dietary manager will randomly question 2 kitchen staff members	09/15/2023

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	155064	A. BUILDING 01 B. WING	08/18/2023

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			weekly on kitchen fire suppression procedure. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
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, observation, and interview; the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 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 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance	K 0345	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents had the potential to be affected by this alleged deficient	09/15/2023

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	Director and the Administrator on 08/17/23 at 02:57 p.m., the fire system inspection report by the facility's fire alarm vendor stated "Customer has several 139 DEG "Bell Style" old heat detectors that are not tied into the FACP. Suggest removing them as they are not life safety or hooked up to the fire alarm." Based on observation with the with the Maintenance Director on 08/18/23 at 12:30 p.m., there over 10 Bell Style heat detectors throughout the building. Based on interview at the time of record review, the Maintenance Director confirmed there were still 139 DEG "Bell Style" heat detectors that were not tied to the fire system and stated they will schedule a time to have the old heat detectors removed. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference on 08/18/23 at 1:00 p.m. 3.1-19(b)		practice. The DG bell heat detectors will be removed. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director will review the reports from the fire alarm vendor when available and schedule the necessary repairs or removal of outdated equipment to keep the fire monitoring system compliant with life safety code. IV. 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 admin or designee will review all reports from the fire alarm vendor and work orders to ensure all recommendation to keep the system life safety compliant are completed timely. The maintenance director or designee will audit the fire suppression equipment testing records monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service 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 2 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 records review with the Maintenance Director and the Administrator on 08/18/23 at 12:42 p.m., there were two conflicting fire watch policies. The fire watch plan located in the Emergency Preparedness binders failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. There was an updated policy that was printed off from the computer that did contain IDOH Gateway but was not in the EPP binders. Based on interview during the record review, the Administrator stated all the old policies will be replaced with the most updated	K 0346	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents had the potential to be affected by this alleged deficient practice. The updated fire watch policy was placed in the emergency preparedness binder. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All emergency preparedness binders will be reviewed and updated annually by the IDT. IV. How the corrective action(s) will be monitored to ensure the	09/15/2023

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	copy. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference on 08/18/23 at 1:00 p.m. 3.1-19(b)		deficient practice will not recur i.e., what quality assurance program will be put into place; The admin or designee will audit the Emergency preparedness binders annually to ensure they are up to date and have matching policies and procedures in them. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
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 policies in	K 0354	I. What corrective action(s) will be accomplished for those residents	09/15/2023

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	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 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 records review with the Maintenance Director and the Administrator on 08/18/23 at 12:42 p.m., there were two conflicting fire watch Policies. The fire watch plan located in the Emergency Preparedness binders failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. There was an updated policy that was printed off from the computer that did contain IDOH Gateway but was not in the EPP binders. Based on interview during the record review, the Administrator stated all the old		found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents had the potential to be affected by this alleged deficient practice. The updated fire watch policy was placed in the emergency preparedness binder. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All emergency preparedness binders will be reviewed and updated annually by the IDT. IV. 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 admin or designee will audit the Emergency preparedness binders annually to ensure they are up to date and have matching policies and procedures in them. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA	

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	policies will be replaced with the most updated copy. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference on 08/18/23 at 1:00 p.m. 3.1-19(b)		Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0355 SS=D 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 inspect 2 of over 20 portable fire extinguishers in the communication room each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push to-test pressure indicators. Section 7.2.4.1 states personnel making manual	K 0355	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 8 residents have the potential to be affected by this alleged deficient practice. The 2-fire extinguisher in the communication room and resident smoking area were inspected. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director was	09/15/2023

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	inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect 8 residents in the vicinity of the Communication room and the resident smoking area. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 08/16/23 at 01:10 p.m., the monthly inspection tag on two fire extinguishers, one located in the Communication room and one in the resident smoking area, lacked documentation of a monthly inspection for July 2023. Based on interview at the time of observation, the Maintenance Director confirmed the fire extinguisher located in the Communication room and the fire extinguisher located in the resident smoking area were missing the July 2023 monthly visual inspection. These findings was reviewed with the Administrator and Maintenance Director at the exit conference on 08/18/23 at 01:00 p.m.. 3.1-19(b)		reeducated on the requirement to inspection the fire extinguishers monthly. A monthly checklist with all fire extinguisher's locations was created to ensure no extinguishers are missed. IV. 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 administrator or designee will audit the fire extinguisher inspection tags monthly to ensure they have been inspected. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is 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. Based on observation and interview, the facility failed to ensure 7 of 50 corridor doors resist the passage of smoke and capable of resisting fire for 20 minutes and were not obstructed from closing. This deficient practice could affect up to 14 residents. Findings include: A.) Based on observation with the Maintenance Director on 08/16/23 at 01:10 pm and 1:50 pm, the corridor doors to rooms 100, 102, 108, and 302 had two 3/8-inch holes that went through the doors. Based on interview at the time of observation, the Maintenance Director stated the holes were due to switching the door handles. B.) Based on observation with the Maintenance Director during a tour of the facility from 02:45 p.m. to 3:20 p.m. the corridor doors from resident rooms 106, 108 and 306 would not close and latch because the privacy curtain was in the way. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned corridor doors would not close and latch due to the privacy curtain being in the way. These findings were reviewed with the Administrator and Maintenance Director at the exit conference on 08/18/23 at 01:00 p.m. 3.1-19(b)	K 0363	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 14 residents had the potential to be affected by this deficient practice. The doors on 100,102, 108, and 302 had the handles replaced with proper size handles. The privacy curtains on room 106,108, and 306 were moved to ensure they do not prevent the door from closing. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director will open and close all fire rated doors monthly to ensure they close properly and ensure they are intact. the results will be documented on the preventative maintenance log. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance	09/15/2023

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			program will be put into place; The administrator or designee will audit the maintenance log monthly to ensure are doors are inspected and repairs are made as needed. V. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
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 2 of 6 electrical wirings in the Medical Records room were protected. 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 up to 10 employees in the medical records room. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 08/16/23 at	K 0511	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents had the potential to be	09/15/2023

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	12:30 p.m., in the Medical Records room there were two receptacles with exposed wires due to missing covers. Based on interview at the time of observation, the Maintenance Director agreed there were electrical outlets with exposed wires. This finding was reviewed with the Administrator and Maintenance Director at the exit conference on 08/18/23 at 01:00 p.m. 3.1-19(b)		affected by this alleged deficient practice. The exposed wires were covered in the medical record room. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All receptacles will be inspected monthly to ensure all electrical wires are covered and not exposed to contact. The inspection will be added to the preventive maintenance log. Repairs will be completed as necessary. IV. 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 administrator or designee will audit the preventive maintenance log monthly to ensure no electrical wires are exposed for potential contact. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0711 SS=L	NFPA 101 Evacuation and Relocation Plan			

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	155064	A. BUILDING 01 B. WING	08/18/2023

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Bldg. 01	Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 #1.) Based on observation, record review, and interview, the facility failed to follow the written fire safety plan during an actual fire that resulted in Immediate Jeopardy to residents who rely on staff knowledge of the fire safety plan. This deficient practice affects all residents, staff, and visitors in the facility. This deficiency resulted in an Immediate Jeopardy. The Immediate Jeopardy was identified on 08/16/23 at 10:45 a.m. when it was learned there was a greater than 15-minute delay of activating the fire alarm system once smoke and a burning smell was discovered. The Maintenance Director and the Administrator were notified of the Immediate Jeopardy on 08/16/23. The IJ began around 6:10 p.m. on 08/13/23 when smoke was first discovered in the laundry room and the fire alarm was not activated until at least 15 minutes later. The IJ ended on 08/18/23 at 12:40 p.m. once all staff have been trained on the fire safety procedures and questioned by the surveyor to ensure staff understood the correct fire safety procedures.	K 0711	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The fire safety plan was updated. All staff were in serviced and randomly quizzed on the fire safety plan. The updated plan was placed in all emergency	09/15/2023

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	Findings include: Based on observation with the Maintenance Director and Administrator on 08/16/23 at 11:10 a.m., a dryer in the laundry room showed signs of a fire due to a burnt dryer, soot on the ceiling, spent fire extinguisher, and an activated sprinkler head. Based on records review between 10:30 a.m. and 12:00 p.m., the provided fire safety plan states, "When staff discovers or recognizes a fire, remove residents from danger, activate nearest pull station, and call 911." Based on interviews between 10:00 a.m. and 12:00 p.m., the Administrator stated the following: on 08/13/23 around 6:10 p.m. she received a call that there was smoke and a smell in the laundry room. Within five minutes the administrator arrived at the facility, she did not see smoke but there was a "toxic" smell in the laundry room, and she sent laundry staff home. The administrator returned home and got a call at 6:30 p.m. that the fire alarm system was activated. Evacuation began and fire department extinguished the fire. LPN #2 stated the following via phone call: she noticed smoke and a smell of melting plastic in the laundry room, called the Administrator, closed the smoke doors, and placed towels down to prevent smoke and the smell from traveling to other parts of the building, but did not activate the fire alarm system. About 15-20 minutes later LPN #2 heard a man banging on the back door saying there is fire coming from the roof. LPN #2 asked CNA #1 to activate the pull station, and CNA #1 did pull the alarm station. LPN # 1 confirmed LPN #2s account of the situation and stated once the fire alarm was activated, evacuation of residents began. The Maintenance Director and Administrator agree that staff did not activate the fire alarm system		preparedness binders. Fire drills we be conducted monthly. The results of the fire drill be documented on the fire drill log. IV. 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 fire drill log will be audited monthly to ensure the fire safety policy is followed. The emergency preparedness binders will be reviewed annually to ensure the most up to date policy is in all binders. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	upon discovery of fire, and delayed resident evacuation by 15 to 20 minutes. The lack of proper response by the facility staff exposed residents to a fire hazard for greater than 15 minutes. The finding was reviewed with the Maintenance Director, Administrator, and the Regional Director via phone call on 08/16/23 at 10:45 a.m. The Administrator and Maintenance Director was informed the IJ was removed on 08/18/23 at 12:40 p.m. #2.) Based on record review and interview, the facility failed to provide 1 of 1 complete and non-conflicting written emergency fire safety plan that incorporated all items listed in NFPA 101, Section 19.7.2.2. 1. Use of alarms. 2. Transmission of alarms to fire department. 3. Emergency phone call to fire department. 4. Response to alarms. 5. Isolation of fire. 6. Evacuation of immediate area. 7. Evacuation of smoke compartment. 8. Preparation of floors and building for evacuation. 9. Extinguishment of fire. This deficient practice affects all residents, staff and visitors in the event of an emergency. Findings include: Based on records review with the Maintenance Director and the Administrator 08/16/23 at 12:07 p.m., there were a total of three different fire safety plans with conflicting and incomplete fire safety			

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	procedures. On 08/18/23 at 12:15 p.m., an updated fire safety plan was provided with all required information. Based on interview on 08/18/23 at 12:15 p.m., the Administrator stated all other copies of the fire safety plan will be replaced with the updated copy. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference on 08/18/23 at 1:00 p.m. 3.1-19(b)			
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure 12 of the last 12 fire drills include simulation of emergency fire conditions. LSC 19.7.1.4 stated fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director and the Administrator on 08/16/23 at	K 0712	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All	09/15/2023

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	12:33 p.m., the fire drill form did not include simulation of emergency fire conditions such as location and type of simulated fire. Based on interview on 08/18/23 at 12:50 p.m., the Maintenance Director agreed the fire drill form did not include the type of fire or location of fire. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference on 08/18/23 at 1:00 p.m. 3.1-19(b) 3.1-51(c)		residents have the potential to be affected by this alleged deficient practice. A fire drill with all the required components will be conducted. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director was in serviced on all the required components of a fire drill. The fire drill log was revised to include all the required components. IV. 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 administrator or designee will audit the fire drill log month to ensure all required components of a fire drill are followed. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and			

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	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 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 2 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect staff and 10 residents and staff in the smoking areas. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 08/16/23 at	K 0741	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 10	09/15/2023

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	12:35 p.m., in the two smoking areas there were over 30 cigarette butts disposed on the ground in and around the smoking areas. At the rear smoking area there was trash mixed with the cigarette butts in the noncombustible container. Also, there were cigarette butts on the ground by the front exit and employee exit. Based on interview at the time of observations, the Maintenance Director agree there were cigarette butts on the ground in the aforementioned locations and there was trash mixed in with the cigarette butts in the noncombustible container in the rear smoking area. This finding was reviewed with the Administrator and Maintenance Director during the exit conference on 08/18/23 at 01:00 p.m. 3.1-19(b)		residents have the potential to be affected by this alleged deficient practice. All the cigarette butts were picked up and placed in the proper container. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff and residents that smoke will be re-educated on the proper disposal of cigarette butts. The housekeeping supervisor will the inspect the smoking area 5 times a week for 4 weeks then weekly and document the findings on the smoking area audit form to ensure all cigarette butts are properly disposed of. IV. 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 administrator audit the smoking area audit form weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 Based on observation and interview, the facility failed to ensure combustible decorations covering 1 of 50 corridor doors to the resident rooms did not exceed more than 30 percent of the door. LSC 18.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs,	K 0753	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 8 residents have the potential to be affected by this alleged deficient practice. The colored paper was removed from the resident's door. III. What measures will be put into place and what systemic changes will be made to ensure that the	09/15/2023

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	paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 18.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. This deficient practice could affect 8 residents in the 300 Hall. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 08/16/23 at 02:25 p.m., 75% of resident room door to room 317 was covered by combustible paper coloring sheets. Based on interview at the time of the observation, the Maintenance Director agreed the corridor door was 75% covered with a combustible material. This finding was reviewed with the Administrator and Maintenance Director at the exit conference		deficient practice does not recur; The activity staff was in serviced on the regulation for combustible decorations. The activity director will inspect all areas with combustible decorations weekly to ensure they meet the requirements. IV. 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 administrator or designee will review the audit form weekly to ensure compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	on 08/18/23 at 01:00 p.m. 3.1-19(b)			
K 0911 SS=E Bldg. 01	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) Based on observation and interview, the facility failed to ensure access and working space was maintained in 1 of 1 electrical panel in the mechanical room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A) (1), (2) and (3). 110.26(A) (1) states the depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) which the minimum clear distance is 3feet. 110.26(A) (2) states the width of the working space in front of the electrical equipment shall be the width of the equipment or 762 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged	K 0911	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 10 residents had the potential to be affected by this alleged deficient practice. The storage items were removed in front of the electrical panel to allow for minimum working space. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director was in serviced on the minimum working	09/15/2023

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	panels. 110.26(A)(3) states the work space shall be clear and extend from the grade, floor, or platform to a height of 6 and 1/2 feet or the height of the equipment, whichever is greater. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the mechanical room. Findings include: Based on observation with the Maintenance Director during a tour of the facility at 02:05 p.m. there were boxes and equipment stored in front of the electrical panel on the wall in the mechanical room . Based on interview at the time of the observations, the Maintenance Director stated acknowledged the aforementioned items were stored within the working space in front of the electrical panel in the mechanical room. This finding was reviewed with the Administrator and Maintenance Director at the exit conference on 08/18/23 at 01:00 p.m. 3.1-19(b)		space requirement for electrical equipment. The maintenance director will inspect the space around electoral equipment weekly to ensure the minimum working space requirement is maintained and document it on the preventive maintenance log. IV. 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 admin will audit the preventive maintenance log weekly to ensure minimum working space around electoral equipment is being maintained. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0914 SS=C Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals			

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(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
	defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review and interview, the facility failed to ensure the testing form for the hospital grade electrical receptacles in 50 of 50 resident sleeping rooms showed that each receptacle was tested. NFPA 99, Health Care Facilities Code 2012 Edition, section 6.3.4.2.1.2 states at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This deficient practice could affect all residents. Findings include: Based on record review with the with the Maintenance Director and the Administrator on 08/16/23 at 12:12 p.m., the electric receptacle testing form dated 01/10/23 indicated only the room number of the receptacles tested and did not indicate which receptacle in each room have met, or have failed to meet, the performance requirements. Based on interview on 08/18/23 at	K 0914	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. All outlets were tested as for polarity and retention with all outlets passing and the form showing the room, location and pass/fail. III. What measures will be put into place and what systemic changes	09/15/2023

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	155064	A. BUILDING 01 B. WING	08/18/2023

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	12:50 p.m., the Maintenance Director agreed the receptacle testing form only indicated the room numbers and did not indicate that each receptacle in each room was tested. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference on 08/18/23 at 1:00 p.m. 3.1-19(b)		will be made to ensure that the deficient practice does not recur; The maintenance director was in serviced on outlet testing and the form changed to add date, room, location, and pass/fail. IV. 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 admin will audit receptacle retention testing form annually to ensure completion. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
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.			

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	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 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 record review, observation, and interview; the facility failed to ensure 1 of 1 Type 2 natural gas emergency generator were maintained in accordance with NFPA 99 Chapter 6 and NFPA 110 Chapter 8. This deficient practice could affect all residents, staff, and visitors. Findings include: A.) Based on record review with the Maintenance Director and the Administrator on 08/16/23 at 12:15 p.m., the thirty-six-month period emergency generator testing documentation for four continuous hours for the natural gas fired emergency generator was not available for review. Based on observations with the Maintenance	K 0918	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice.	09/15/2023

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	Director on 08/18/23 at 12:30 p.m., the facility has one natural gas fired emergency generator outside on the west side of the building. Based on interview on 08/18/23 at 12:50 p.m., the Maintenance Director stated the facility has one natural gas fired emergency generator and acknowledged the documentation was not provided during the survey. B.) Based on record review with the Maintenance Director and the Administrator on 08/16/23 at 12:12 p.m., documentation for half of the monthly load tests were missing the 5-minute cool down and the transfer time. Based on interview on 08/18/23 at 12:50 p.m., the Maintenance Director agreed some of the load test information was not recorded on every load check. C.) Based records review with the with the Maintenance Director and the Administrator on 08/16/23 at 12:19 p.m., no documentation of a fuel reliability from the facility's natural gas carrier was not provided for review. Based on interview on 08/18/23 at 12:50 p.m., the Maintenance Director stated the fuel reliability letter from the gas company could not be found. The findings were reviewed with the Maintenance Director and the Administrator during the exit conference on 08/18/23 at 1:00 p.m. 3.1-19(b)		III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; If documentation cannot be found for a 4 hour load test in the last 36 months a 36 month load test will be completed. A reliability letter from the gas company will be obtained. The monthly generator load test form will be amended to account for a 30-minute run and an addition 5-minute cool down for a total of 35 minutes. IV. 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 administrator will audit the generator load test monthly to ensure to regulation is being followed. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage			

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	Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility	K 0923	I. What corrective action(s) will be	09/15/2023

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	failed to ensure empty cylinders are segregated from full cylinders and are marked to avoid confusion. This deficient practice could affect up to 15 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director on 08/16/23 at 01:25 p.m. in the oxygen storage room and at 03:30 p.m. in the outside oxygen storage building there was no means to separate full oxygen cylinders from empty oxygen cylinders therefore empty cylinders were intermingled with full cylinders. Based on interview at the time of observation, the Maintenance Director stated that the empty oxygen cylinders were mixed with full cylinders. These findings were reviewed with the Administrator and Maintenance Director during the exit conference on 08/18/23 at 01:00 p.m.. 3.1-19(b)		accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 15 residents have the potential to be affected by this alleged deficient practice. The empty oxygen tanks were separated from the full ones and marked empty. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A full and empty side was designated and marked in the oxygen storage room. The nursing staff were in serviced on proper oxygen storage and transfer. The maintenance director will make weekly rounds to ensure oxygen is properly stored and transferred and will document the results on the preventive maintenance log. IV. 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 administrator or designee will audit the maintenance log monthly to ensure proper storage and transfer	

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			of oxygen is occurring. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
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) Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage/transfer rooms was provided with a sign indicating that transferring is occurring. NFPA 99 11.5.2.3.1(3) states, the area is posted with signs indicating that trans-filling is occurring and that smoking is the immediate area is not permitted. This deficient practice could affect 20 residents in one smoke compartment. Findings include:	K 0927	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 20	09/15/2023

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	Based on observations with the Maintenance Director on 08/18/23 at 12:33 p.m., the oxygen transfilling room contained liquid oxygen tanks. The door to the room was not provided with sign that indicates when transfilling of oxygen is occurring. Based on interview at the time of observation, the Maintenance Director stated there was not a sign that indicates when transfilling of oxygen is occurring. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference on 08/18/23 at 1:00 p.m. 3.1-19(b)		residents have the potential to be affected by this alleged deficient practice. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A transferring of oxygen sign was added to the oxygen room. Nursing staff were in serviced on proper transferring of oxygen and signs that must remain in place. IV. 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 maintenance director will audit the oxygen rooms weekly to ensure the transferring of oxygen signs remain in place outside of all oxygen rooms. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	