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	08/23/2022

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 Date: 08/23/22 Facility Number: 000025 Provider Number: 155064 AIM Number: 100274850 At this Emergency Preparedness survey, Aperion Care Kokomo was found in substantial 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 57. Quality Review completed on 08/29/22	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 by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
E 0004 SS=C 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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeff Attinger	RVP of Operations	02/06/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Federal, State and local emergency 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 develop and maintain an emergency	E 0004	I. What corrective action(s) will be accomplished for	10/04/2022

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	preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan on 08/23/22 between 10:05 a.m. to 10:36 a.m., documentation for a complete emergency program reviewed by the facility within the most recent twelve-month period was not available for review. The emergency preparedness plan available has not been reviewed within the past 12 months with the last documented review date being listed as 02/14/2019. Based on interview at the time of record review, the Administrator stated that he thought the plan had been reviewed, but documentation presented only showed a small part of the plan had been reviewed and no review date was added to the actual Emergency plan itself. During the exit conference with the facility Regional Vice President, the Administrator-in-Training, and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding.		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 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 inserviced 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 also check the date of the last update of the emergency preparedness plan to ensure it is	

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			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 0013 SS=C 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			

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	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 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			

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	failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to develop and maintain emergency preparedness policeis and procedures that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan on 08/23/22 between 10:05 a.m. to 10:36 a.m., documentation of policies and procedures reviewed by the facility within the most recent twelve-month period was not available for review. The emergency preparedness plan available has not been reviewed within the past 12 months with the last documented review date being listed as 02/14/2019. Based on interview at the time of record review, the Administrator-in-Training stated that he thought the plan had been reviewed, but documentation presented only showed a small part of the plan had been reviewed and no review date was added to the actual Emergency plan itself. During the exit conference with the facility Regional Vice President, the Administrator-in-Training, and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding.	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 inserviced 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.	10/05/2022

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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 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 0029 SS=C 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), 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			

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	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 develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan on 08/23/22 between 10:05 a.m. to 10:36 a.m., documentation for a communications plan reviewed by the facility within the most recent twelve-month period was not available for review. The emergency preparedness plan available has not been reviewed within the past 12 months with the last documented review date being listed as 02/14/2019. Based on interview at the time of record review, the Administrator-in-Training stated that he thought the plan had been reviewed, but documentation presented only showed a small part of the plan had been reviewed and no review date was added to the actual Emergency plan itself. During the exit conference with the facility Regional Vice President, the Administrator-in-Training, and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding.	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 inserviced on the emergency preparedness 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	10/04/2022

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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 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=C 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). *[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			

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	§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 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).			

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	*[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 develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan on 08/23/22 between 10:05 a.m. to 10:36 a.m., documentation of a testing and training program reviewed by the facility within the most recent twelve-month period was not available for review. The emergency preparedness plan available has not been reviewed within the past 12 months with the last documented review date being listed as 02/14/2019. Based on interview at the time of record review, the Administrator-in-Training stated that he thought the plan had been reviewed, but documentation presented only showed a small part of the plan had been reviewed and no review date was added to the actual Emergency plan itself. During the exit conference with the facility Regional Vice President, the Administrator-in-Training, and the	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 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	10/04/2022

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	Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding.		recur; The IDT was inserviced on the emergency preparedness 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.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/23/22	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*	

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	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 Type II (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 105 and had a census of 57 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 08/29/22		*constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
K 0200 SS=E Bldg. 01	NFPA 101 Means of Egress Requirements - Other Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress 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. 18.2, 19.2			

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	155064	A. BUILDING 01 B. WING	08/23/2022

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	Based on observation and interview, the facility failed to ensure 1 of 3 doors to the kitchen was provided with door latches that required only one operation to open. LSC 19.2.2.1 states doors complying with 7.2.1 shall be permitted. 7.2.1.5.10.2 requires the releasing mechanism shall open the door leaf with not more than one releasing operation. This deficient practice could affect all staff in the kitchen area. Findings include: Based on observations made during a tour of the facility with Maintenance Director and the Administrator-in-Training on 08/23/22 at 2:14 p.m., the kitchen door leading to the main dining room was equipped with an independent dead bolt in addition to the doorknob. Based on interview at the time of observation, The Maintenance Director acknowledged the kitchen door to the main dining area as having an independent dead bolt as well as a door handle with a latching mechanism and stated that he would fix the issue as soon as he could find the time to do so. During the exit conference with the facility Regional Vice President, the Administrator-in-Training, and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)	K 0200	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents had the potential to be 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 affected by this alleged deficient practice. The deadbolt lock was removed from the kitchen door. An inspection of all doors were completed to ensure on doors that need to be locked, there was only one locking mechanism. I. 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 complete the door inspection form before adding a locking mechanism to the door to ensure one is not already in place. IV. How the corrective action(s) will be monitored to	10/04/2022

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			ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The maintenance director or designee will audit all locking doors monthly to ensure only one locking mechanism is in place. 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 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 1) Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in 1 of 8 corridors within the facility. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60	K 0211	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	10/04/2022

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	in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect approximately 12 residents, 2 staff and 1 visitor. Findings include: Based on observations made during a tour of the facility with Maintenance Director and the Administrator -in-Training on 08/23/22 at 1:40 p.m., there was a small plastic 3-drawer chest sitting immediately outside resident room #301. This 3-drawer chest contained P.P.E. for staff, and it was not on wheels. Based on interview with the Maintenance Director at the time of the observation, he acknowledged the 3-drawer chest as being stored in the corridor and agreed that it was not on wheels. During the exit conference with the facility Regional Vice President , the Administrator-in-Training, and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) 2) Based on observation and interview, the facility failed to ensure 1 of 5 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect approximately 12 residents, 2 staff		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; 12 residents had the potential to be affected by this alleged deficient practice. Wheels were added to the identified PPE containers. The scale was moved out of the corridor. 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 nursing and housekeeping staff were inserviced on maintaining a free, unobstructed corridor in case of an emergency. The maintenance director or designee will complete walking rounds 5 days a week to ensure the corridors remain unobstructed and record the results on the preventative maintenance log. I. 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 administer or designee will audit all corridors weekly and the maintenance directors daily log to ensure the corridors remain	

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	and 1 visitor. Findings include: Based on the initial walk through of the facility from 9:38 a.m. to 9:43 a.m. on 08/23/22, a 48-inch by 48-inch scale for weighing residents on wheelchairs was sitting in the corridor immediately outside resident room #303. Based on observations made during a tour of the facility with Maintenance Director and the Administrator-in-Training on 08/23/22 at 1:42 p.m., the aforementioned scale was located in the same position as it was during the initial walk through of the facility and was not currently in use. Based on interview with the Maintenance Director at the time of the observation, he acknowledged the scale as being stored in the corridor and further agreed that it was not currently in use. During the exit conference with the facility Regional Vice President , the Administrator-in-Training, and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		unobstructed. 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 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			

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	permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall			

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	be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 7 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 12 residents, 2 staff and 1 visitor needing to exit the facility in an emergency situation. Findings include: Based on observations made during a tour of the facility with Maintenance Director and the Administrator-in-Training on 08/23/22 at 1:40 p.m., the door near resident room #129 on Harmony Hall was marked as a facility exit, was magnetically locked, and could be opened by entering a four-digit code but the code was not posted at the exit. The Administrator-in-Training stated that the code was not posted by the door to prevent residents from eloping, but after a short conversation, understood the necessity for the code to be posted for emergency situations.	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; 12 residents had the potential to be affected by this alleged deficient practice. The code was posted nest to the keypad for door near resident 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; The maintenance director will check for door code placement	10/04/2022

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	During the exit conference with the facility Regional Vice President , the Administrator-in-Training, and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		on all exit doors without a delayed egress weekly to ensure they remain 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 the door code placement checks 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			

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	automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) 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 the corridor door to 1 of 1 door to a hazardous area such as a House Keeping room, a Bio-hazard room, or a storage room of combustible supplies over 50 square feet in size, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect Findings include: Based on observations made during a tour of the facility with Maintenance Director and the Administrator-in-Training on 08/23/22 at 1:23 p.m., the corridor door to the room identified as "the Dogwood Room", a room that had been converted to a storage room, did not have a self-closing	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	10/04/2022

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	device attached to it. This room contained well over 200 boxes of assorted P.P.E. and was approximately 400 square feet in size or approximately 20 feet by 20 feet. Based on an interview at the time of the observation, the Maintenance Director agreed that the room was hazardous and stated that he would add a self-closing device to the door or move the storage to another appropriate location as soon as he could. During the exit conference with the facility Regional Vice President , the Administrator-in-Training, and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		hazardous areas were audited for a self-closing device. a self-closing device was added to the Dogwood storage 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; A weekly inspection of doors on all rooms considered a hazardous area was added to 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 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 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and			

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	Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, Section 14.4.5.3.1 states smoke detector sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states smoke detector sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with Section 14.4.5.3.3. This deficient practice could affect all occupants. Findings include: Based on record review with Maintenance Director and the Administrator-in-Training on 08/23/22 at 12:08 p.m., a current fire alarm sensitivity test documenting the smoke detector type, the range of that smoke detector, and the trip point at which the device tested alarmed at, was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition and stated that he would contact the	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 tis 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. 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 sensitivity testing documentation was obtained showing sensitivity was tested in December of 2020 and is scheduled to be completed again in December of 2022. Additional copies of all fire suppression equipment will be maintained in	10/04/2022

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	vendor for additional paperwork. As of the time of the exit conference at 3:50 p.m., this documentation could still not be provided for review. During the exit conference with the facility Regional Vice President , the Administrator-in-Training, and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		the administrators office. 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 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.	
K 0351 SS=F Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed			

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	6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure that a complete automatic sprinkler system was provided for 1 of 1 exterior overhang. NFPA 13, Standard for Installation of Sprinkler Systems, 2010 Edition, Section 8.15.7.1 states sprinklers shall be installed under exterior roofs, canopies, porte-cocheres, balconies, decks, or similar projections exceeding 4 ft. (1.2 m) in width. Section 8.15.7.2 states sprinklers shall be permitted to be omitted where the canopies, roofs, porte-cocheres, balconies, decks, or similar projections are constructed with materials that are noncombustible or limited combustible, or fire retardant. This deficient practice could affect at least 15 residents, 4 staff and 2 visitors using the main entry to the facility. Findings include: Based on observations made during a tour of the facility with Maintenance Director and the Administrator-in-Training on 08/23/22 at 1:23 p.m., the framing for the exterior overhang at the main entrance of the facility was constructed of wood. This canopy extended approximately seven-nine inches feet from the building and was not sprinkled underneath. In addition, the underside of the overhang at the main entrance was constructed of wood. Based on interview at the time of the observations, the Maintenance Director agreed that the main entrance overhang was constructed of wood, extended more than four feet from the building, and was not sprinkled underneath the overhang. During the exit	K 0351	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; 15 residents had the potential to be affected by this alleged deficient practice. A complete sprinkler system will be added to the exterior overhang. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Before any new construction occurs, it will be reviewed for the need of a sprinkler system. 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	03/28/2023

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	conference with the facility Regional Vice President , the Administrator-in-Training, and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		place; The administrator will review the physical plant monthly to ensure no new construction has occurred. 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 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1) Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler	K 0353	I. What corrective action(s)	10/04/2022

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	piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, Section 14.2.1. Section 14.2.1 states, "except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice affects all residents, staff, and visitors. Findings include: Based on record review with Maintenance Director and the Administrator-in-Training on 08/23/22 at 1:20 p.m., documentation for a current 5-year internal pipe investigation for the facility sprinkler system could not be provided for review. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition and stated that he would contact the vendor for additional paperwork. As of the time of the exit conference at 3:50 p.m., this documentation could still not be provided for review. During the exit conference with the facility Regional Vice President , the Administrator-in-Training, and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) 2) Based on observation and interview, the facility failed to ensure 1 of 1 private fire hydrant was		will be accomplished for those residents found to have been affected by the deficient practice; No residents had the potential to be 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. An inspection of the internal pipes, and repair of the fire hydrate will be completed 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 sprinkler system maintenance and testing schedule was added to the preventive maintenance log and will be verified monthly 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 The results of these audits will be	

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	continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2011 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Table 7.1.1.2 requires wet and dry barrel hydrants to be inspected annually and after each operation. This deficient practice affects all residents in the facility. Findings include: Based on record review with Maintenance Director and the Administrator-in-Training on 08/23/22 at 2:20 p.m., the fire hydrant document entitled 'Fire Hydrant Inspection" dated 09/14/2021 stated that the inspection failed. Further review under the comments section stated, "Hydrant will not open, the valve is "FROZEN" and will require excavation to repair." Based on an interview with the Maintenance Director at 2:20 p.m., no documentation could be provided to show the fire hydrant had been repaired, or any action taken as a result of this inspection. During the exit conference with the facility Regional Vice President, the Administrator-in-Training, and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		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 0355 SS=F 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.			

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	18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to inspect all portable fire extinguishers within the facility. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 says Fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. This deficient practice could affect all residents, staff, and visitors within the facility. Findings include: Based on observations made during a tour of the facility with Maintenance Director and the Administrator-in-Training on 08/23/22 at 1:00 p.m., the portable fire extinguisher located immediately across from the Admissions Directors office was missing the July 2022 monthly inspection. Further observations made during the continuing tour of the facility found all portable fire extinguishers located throughout the facility were in fact missing the July 2022 monthly inspection. Based on an interview at the time of each observation, the Maintenance Director stated that he must have been busy and forgot to do the monthly portable fire extinguisher inspections in July of 2022. During the exit conference with the facility Regional Vice President, the Administrator-in-Training, and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)	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; No residents had the potential to be affected by this alleged deficient practice. The portable fire extinguishers were all 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 will audit the portable fire extinguishers week to ensure they are inspected at least monthly and record the results of audit 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	10/04/2022

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			designee will review 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 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			

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	unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 9 of 49 sets of resident room doors to the corridor would close completely and latch into the door frame. This deficient practice could affect approximately 40 residents, as well as staff and visitors. Findings include: Based on observations made during a tour of the facility with Maintenance Director and the Administrator-in-Training on 08/23/22 from 12:45 a.m. to 2:31 p.m. the following was noted: 1) Resident room #162 door failed to fully and close and latch into the frame because a privacy curtain obstructed the corridor door 2) Resident room #117 door failed to close and latch into the frame 3) Resident room #108 door failed to close and latch into the frame 4) Resident room #109 door failed to close and latch into the frame 5) Resident room #102 door failed to close and	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; 40 residents had the potential to be affected by this deficient practice. All fire rated doors were opened and closed to ensure they all closed correctly and latched. The doors identified on the 2567 were the only doors noted not to close and latch properly. The doors will be adjusted or replaced to ensure they properly close and latch.	10/04/2022

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	latch into the frame 6) Resident room #111 door was extremely difficult to close and failed to latch into the frame 7) Resident room #123 failed to close and latch into the frame 8) Resident room #127 door was extremely difficult to close and failed to latch into the frame 9) Resident room #306 failed to close and latch into the frame Based on an interview at the time of observations, the Maintenance Director acknowledged the aforementioned conditions stating that he would work on the doors as soon as he had time to do so. During the exit conference with the facility Regional Vice President, the Administrator-in-Training, and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding. 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; The maintenance director will open and close all fire rated doors monthly to ensure they close and latch properly. 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 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. 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 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors			

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	2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 3 of 6 sets of barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 32 residents, as well as 4 staff and 2 visitors. Findings include: Based on observations made during a tour of the facility with Maintenance Director and the Administrator-in-Training on 08/23/22 from 12:45 a.m. to 2:31 p.m. the following was noted: 1) the barrier doors nearest to the Activities room failed to fully close leaving a three-inch gap when coming together to the closed position. 2) the barrier doors nearest to the "Dogwood Room" failed to fully close leaving a two-inch gap when coming together to the closed position. 3) the barrier doors nearest to Resident room #304 failed to fully close leaving a three-inch gap when	K 0374	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; 32 residents had the potential to be affected by this alleged deficient practice. All barrier doors were inspected to ensure proper closure. The 3 barrier doors listed on the 2567 were the only doors not to close properly and were adjusted. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	10/04/2022

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	coming together to the closed position. Based on an interview at the time of observations, the Maintenance Director acknowledged the aforementioned conditions stating that he would work on the doors as soon as he had time to do so. During the exit conference with the facility Regional Vice President, the Administrator-in-Training, and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		All barrier doors will be inspected monthly to ensure proper closure. The results of the inspection 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 program will be put into place; The administrator will audit the maintenance log monthly to ensure doors are inspected and functioning properly. 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 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			

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	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 1 of 1 area where smoking was permitted for staff and residents was maintained in accordance with 19.7.4. LSC 19.7.4 requires ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. Metal containers with a self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas were smoking is permitted. This deficient practice could affect all smoking residents and staff as well as visitors in the facility. Findings include: Based on observations made during a tour of the facility with Maintenance Director and the Administrator-in-Training on 08/23/22 at 1:30 p.m., there was a 2 ½ gallon plastic bucket half full of salt pellets, around 150 cigarette butts, and 8 empty cardboard cigarette containers sitting on	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; All residents that smoke have the potential to be affected by this alleged deficient practice. The smoker area was cleaned, and the non-approved container was removed.	10/04/2022

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	the sidewalk in the designated smoking area. This container was not an approved metal container with a self-closing device on it. Based on interview at the time of observation, the Maintenance Director agreed that this was not an approved container and removed it from the area. This deficiency was removed prior to my exiting of the facility. 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; All staff and smoking residents will be inserviced on proper disposal of smoking material. The housekeeping department will audit the smoking area daily to ensure no unapproved containers are in place and that smoking material are properly disposed of. The results will be documented on the smoking area inspection audit 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 smoking area inspection audit weekly to ensure smoking material are properly disposed of. 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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(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
K 0914 SS=F 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 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 observation, record review and interview, the facility failed to ensure all nonhospital-grade electrical receptacles at resident room locations were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical	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	10/04/2022

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	155064	A. BUILDING 01 B. WING	08/23/2022

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	integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 gram (4 ounces). This deficient practice could affect all residents. Findings include: Based on record review with Maintenance Director and the Administrator-in-Training on 08/23/22 at 11:20 a.m., there was receptacle retention testing documentation to test the physical integrity, continuity, or polarity of the resident room receptacles available for review, but it was incomplete. Only roughly one-quarter of the rooms tested were complete with the rest of the document being left blank. Based on interview at the time of records review, the Maintenance Director stated that he started the test, but must have overlooked completing it. 3.1-19(b)		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 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 inserviced on outlet testing. Semi-annual outlet testing for polarity and retention will be conducted every September and March. 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 every October and April 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	

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			plan of correction as indicated.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 2 of 37 resident rooms did not use flexible cords as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects as many as 12 residents,	K 0920	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	10/04/2022

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	4 staff and 1 visitor. Findings include: Based on observations made during a tour of the facility with Maintenance Director and the Administrator-in-Training on 08/23/22 at 1:38 p.m., there was a power strip in use and dangling from an electric receptacle in the Harmony Hall nurses station. Based on an interview at the time of the observation, the Maintenance Director acknowledged the use of the power strip, unplugged it, and removed it from the area. This deficiency was removed prior to exiting of the facility. 3.1-19(b)		the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 12 residents have the potential to be affected by this alleged deficient practice. The power strip was immediately 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; All staff were inserviced on appropriate power strip usage. 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 or designee will round the building monthly to ensure no improper power strips are used and will document the results on the power strip audit. 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 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage 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			

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	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 failed to ensure 1 of 2 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect 24 staff and visitors in the vicinity of oxygen storage and transfilling room. Findings include: Based on observations made during a tour of the facility with Maintenance Director and the Administrator-in-Training on 08/23/22 at 1:36 p.m., a small green oxygen cylinder was standing upright on the floor of the Harmony Hall nurses station Medicine (Med) room and was not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of observation, the Maintenance Director acknowledged the small oxygen cylinder was standing upright on the floor of the Med room and was not properly chained or supported in a proper cylinder stand or cart. He then removed the small oxygen cylinder and returned it to the oxygen and transfilling room where it belonged. This deficiency was removed prior to exiting of the facility.	K 0923	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; 24 residnets have the potential to be affected by this alleged deficient practice. The oxygen tank was returned to the oxygen 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; The nursing staff were inserviced 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	10/04/2022

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	3.1-19(b)		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 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.	