STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155401	A. BUILDING -- B. WING	09/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BEN HUR HEALTH AND REHABILITATION	1375 S GRANT AVE CRAWFORDSVILLE, IN 47933

(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: 09/20/22 Facility Number: 000461 Provider Number: 155401 AIM Number: 100275290 At this Emergency Preparedness survey Ben Hur Health and Rehabilitation was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 110 certified beds. At the time of the survey, the census was 78. Quality Review completed on 09/22/22	E 0000	**Ben Hur Life Safety Survey POC 2022** The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. **K211: Means of Egress** - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: **Path of Egress was immediately cleared. The rocking chair in front of room 205 and the dining room chair in front of room 401 were immediately removed from hallway.** - 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 **26 residents and 4 staff and**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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			visitors have the potential to be effected. **All staff will be educated on means of egress. All medically necessary items will be stored on one side of the hallway not to reduce the clear unobstructed corridor width to less than 60 in.** - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **IDT will round daily to ensure means of egress are clear and unnecessary items are not being stored in the hallway.** - 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; To ensure compliance, the ED/Designee is responsible for the completion of the **Environmental** CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by	

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	155401	A. BUILDING -- B. WING	09/20/2022

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			the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. - by what date the systemic changes will be completed. **10/07/2022** **K tag: 300 – Protection – Other, Facility failed to replaced battery operated smoke alarms installed in resident sleeping rooms in accordance with NFPA 72.** - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **New smoke alarms were ordered and replaced. (Pic attached of new smoke alarm)** - 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, staff, and visitors in vicinity of rooms 608 and 502 had the potential to be affected.** - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Education provided to**	

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			Maintenance Director regarding smoke alarms and need to be replaced every 10 years. **Maintenance Director/Designee will check every smoke alarm in the building to ensure all are in compliance and maintain a log with expiration dates.** - 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 - To ensure compliance, the ED/Designee is responsible for the completion of the **Smoke Alarm** Rounding Tool CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. - by what date the systemic changes will be completed. **10/07/2022** **K511: Utilities – Gas and Electric**	

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			- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: **Outlet in Beauty Shop was immediately corrected and is GFCI protected against electric shock.** - 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 **Residents or staff utilizing beauty shop have the potential to be affected.** **Maintenance director will be educated on importance of GFCI protection.** - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Maintenance will identify all areas where GFCI protected outlets should be installed and ensure all are working appropriately.** - 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;	

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			To ensure compliance, the ED/Designee is responsible for the completion of the **Environmental** CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. - by what date the systemic changes will be completed. **10/07/2022** **<u>K761: Maintenance, Inspection, & Testing – Doors</u>** - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: **Fire Door was immediately inspected and paint over the rating label was removed. (pic attached of paint removed from label)**	

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			- 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.** - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Oxygen Transfilling Room was added to the annual fire door inspection list.** **Education was provided to the maintenance director.** - 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; To ensure compliance, the ED/Designee is responsible for the completion of the **Fire Door** CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI	

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			committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. - by what date the systemic changes will be completed. **10/07/2022**	
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: 09/20/22 Facility Number: 000461 Provider Number: 155401 AIM Number: 100275290 At this Life Safety Code survey, Ben Hur Health and Rehabilitation 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 facility, which consisted of one-story building additions with a partial basement to a two-story facility, was determined to be of Type V (111) construction and fully sprinklered. The facility also has a separate detached laundry building that is not sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor, and in	K 0000	**Ben Hur Life Safety Survey POC 2022** The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. **K211: Means of Egress** - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: **Path of Egress was immediately cleared. The rocking chair in front of room 205 and the dining room chair in front of room 401 were immediately removed from**	

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	resident Room 612 and 613 in Wing 9. The facility has battery operated smoke detectors in all other resident sleeping rooms. The facility has a capacity of 110 and had a census of 78 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for a detached equipment storage and maintenance building. Quality Review completed on 09/22/22		**hallway.** - 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 **26 residents and 4 staff and visitors have the potential to be effected.** **All staff will be educated on means of egress. All medically necessary items will be stored on one side of the hallway not to reduce the clear unobstructed corridor width to less than 60 in.** - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **IDT will round daily to ensure means of egress are clear and unnecessary items are not being stored in the hallway.** - 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; To ensure compliance, the ED/Designee is responsible	

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			for the completion of the **Environmental** CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. - by what date the systemic changes will be completed. **10/07/2022** **K tag: 300 – Protection – Other, Facility failed to replaced battery operated smoke alarms installed in resident sleeping rooms in accordance with NFPA 72.** - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **New smoke alarms were ordered and replaced. (Pic attached of new smoke alarm)** - 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, staff, and visitors in vicinity of rooms 608 and 502**	

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			had the potential to be affected. - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Education provided to Maintenance Director regarding smoke alarms and need to be replaced every 10 years.** **Maintenance Director/Designee will check every smoke alarm in the building to ensure all are in compliance and maintain a log with expiration dates.** - 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 - To ensure compliance, the ED/Designee is responsible for the completion of the **Smoke Alarm** Rounding Tool CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be	

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			developed to ensure compliance. - by what date the systemic changes will be completed. **10/07/2022** **K511: Utilities – Gas and Electric** - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: **Outlet in Beauty Shop was immediately corrected and is GFCI protected against electric shock.** - 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 **Residents or staff utilizing beauty shop have the potential to be affected.** **Maintenance director will be educated on importance of GFCI protection.** - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Maintenance will identify all areas where GFCI protected**	

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			outlets should be installed and ensure all are working appropriately. - 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; To ensure compliance, the ED/Designee is responsible for the completion of the **Environmental** CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. - by what date the systemic changes will be completed. **10/07/2022** **<u>K761: Maintenance, Inspection, & Testing – Doors</u>** - what corrective action(s) will	

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			be accomplished for those residents found to have been affected by the deficient practice: **Fire Door was immediately inspected and paint over the rating label was removed. (pic attached of paint removed from label)** - 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.** - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Oxygen Transfilling Room was added to the annual fire door inspection list.** **Education was provided to the maintenance director.** - 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; To ensure compliance,	

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			the ED/Designee is responsible for the completion of the **Fire Door** CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. - by what date the systemic changes will be completed. **10/07/2022**	
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 Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in 2 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 in. (1525 mm.) (b) The health care occupancy fire safety plan and	K 0211	**Ben Hur Life Safety Survey POC 2022** The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the Plan of Correction be	10/07/2022

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	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 26 residents, 4 staff and visitors. Findings include: Based on observations made on 09/20/22 during a tour of the facility from 11:07 a.m. to 12:40 p.m. with the Maintenance Director, the following was noted: a) a wooden rocking chair being stored in the corridor adjacent to resident room 205. b) a dining room chair was stored in the corridor outside resident room 401. Based on interview with the Maintenance Director at the time of observations, he agreed the means of egress were not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This finding was reviewed with the Executive Director and Maintenance Director at the time of exit. 3.1-19(b)		considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. **K211: Means of Egress** - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: **Path of Egress was immediately cleared. The rocking chair in front of room 205 and the dining room chair in front of room 401 were immediately removed from hallway.** - 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 **26 residents and 4 staff and visitors have the potential to be effected.** **All staff will be educated on means of egress. All medically necessary items will be stored on one side of the hallway not to reduce the clear unobstructed corridor width to less than 60 in.** - what measures will be put into place or what systemic changes will be made to ensure	

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BEN HUR HEALTH AND REHABILITATION	1375 S GRANT AVE CRAWFORDSVILLE, IN 47933

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			that the deficient practice does not recur; **IDT will round daily to ensure means of egress are clear and unnecessary items are not being stored in the hallway.** - 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; To ensure compliance, the ED/Designee is responsible for the completion of the **Environmental** CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. - by what date the systemic changes will be completed. **10/07/2022**	
K 0300 SS=E 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			

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	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 observation and interview, the facility failed to replace 2 of 63 battery operated smoke alarms installed in resident sleeping rooms in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect over 15 residents, staff, and visitors in the vicinity of Rooms 608, and 502. Findings include: Based on observations with the Maintenance Director on 09/20/22 during a tour of the facility from 11:07 a.m. to 12:40 p.m., manufacturer's documentation affixed to the battery operated smoke alarms installed on the ceiling in resident sleeping rooms 608 and 502 indicated each device was manufactured 03/14/2012. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned smoke alarms were more than ten years old and would check the rest of the battery operated smoke detectors as they were all installed at the same time. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)	K 0300	**K tag: 300 – Protection – Other, Facility failed to replaced battery operated smoke alarms installed in resident sleeping rooms in accordance with NFPA 72.** - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **New smoke alarms were ordered and replaced. (Pic attached of new smoke alarm)** - 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, staff, and visitors in vicinity of rooms 608 and 502 had the potential to be affected.** - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Education provided to Maintenance Director regarding smoke alarms and need to be replaced every 10**	10/07/2022

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			years. **Maintenance Director/Designee will check every smoke alarm in the building to ensure all are in compliance and maintain a log with expiration dates.** - 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 - To ensure compliance, the ED/Designee is responsible for the completion of the **Smoke Alarm** Rounding Tool CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. - by what date the systemic changes will be completed. **10/07/2022**	
K 0511 SS=D 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			

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	Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 2 wet locations in the beauty shop was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle	K 0511	**K511: Utilities – Gas and Electric** - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: **Outlet in Beauty Shop was immediately corrected and is GFCI protected against electric shock.** - 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 **Residents or staff utilizing beauty shop have the potential to be affected.** **Maintenance director will be educated on importance of GFCI protection.** - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Maintenance will identify all areas where GFCI protected outlets should be installed and**	10/07/2022

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	outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect at least 2 residents and staff in the beauty shop. Findings include: Based on observation on 09/20/22 between 11:07 a.m. and 12:40 p.m. during a tour of the facility with the Maintenance Director, the electric receptacle next to the sink closest to the door in the beauty shop was provided with a GFCI receptacle, however, when tested with a GFCI testing device, it did not break the circuit. Based		**ensure all are working appropriately.** - 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; To ensure compliance, the ED/Designee is responsible for the completion of the **Environmental** CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. - by what date the systemic changes will be completed. **10/07/2022**	

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	on interview at the time of observation, the Maintenance Director agreed the receptacle was not GFCI protected. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)			
K 0761 SS=E Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of at least 1 fire door assembly was completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of	K 0761	**K761: Maintenance, Inspection, & Testing – Doors** - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: **Fire Door was immediately inspected and paint over the rating label was removed. (pic attached of paint removed from label)** - 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.** - what measures will be put into place or what systemic changes will be made to ensure	10/07/2022

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	either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect at least 25 residents and staff. Findings include: Based on record review and interview with the Maintenance Director on 09/20/22 between 9:38 a.m. and 11:05 a.m., no documentation of an annual inspection for the fire door assembly at the Oxygen Transfilling room was available for review. Based on observation during the tour of the facility with the Maintenance Director, the Oxygen Transfilling room, located in 600 Hall, has one door assembly, however the rating label was painted. Based on interview at the time of records		that the deficient practice does not recur; **Oxygen Transfilling Room was added to the annual fire door inspection list.** **Education was provided to the maintenance director.** - 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; To ensure compliance, the ED/Designee is responsible for the completion of the **Fire Door** CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. - by what date the systemic changes will be completed. **10/07/2022**	

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	review and observation, the Maintenance Director stated the annual fire door inspection did not include the Oxygen Transfilling room and he would add it to the annual fire door inspection tasks and remove the paint from the label. The finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)			