STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155029	A. BUILDING -- B. WING	05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY NURSING AND REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218

(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: 05/16/23 Facility Number: 000012 Provider Number: 155029 AIM Number: 100274900 At this Emergency Preparedness survey, Community Nursing and Rehabilitation Center was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 115 certified beds. At the time of the survey, the census was 46. Quality Review completed on 05/17/23	E 0000		
E 0041 SS=C Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power			

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

Keith Davis | senior executive director | 06/02/2023

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

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	systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain			

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

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	(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 05/16/23 at 11:17 a.m., the weekly generator inspection documentation entitled "Direct Supply - TELS Generator testing - no load" and "Direct Supply - TELS Generator testing - under load" had missing testing documentation January 30th to March 6th of 2023. This was a five-week period of time. Based on interview at the time of the observation, the Maintenance Director acknowledged that the above-mentioned generator inspection documents were not available for review adding that the facility was without a Maintenance Director during that period of time.	E 0041	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 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 same potential to be affected by this alleged deficient practice - Maintenance Director educated by the Senior Executive Director on 6/2/23 on generator testing requirements - Facility hired a Maintenance Director on 4/19/23 whom has been educated on generator testing which will ensure future compliance What measures will be put into place or what systemic changes	06/02/2023

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			will be made to ensure that the deficient practice does not recur; - Maintenance Director educated on 6/2/23 by the Senior Executive Director on appropriate generator testing - Maintenance to conduct audits to ensure compliance (see Attachment C) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as Generator testing (see Attachment C) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 6/2/23	

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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: 05/16/23 Facility Number: 000012 Provider Number: 155029 AIM Number: 100274900 At this Life Safety Code survey, Community Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two-story facility was determined to be of Type II (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in resident sleeping rooms 133 through 141 and 233 through 237. The facility has smoke detectors hard wired to the fire alarm system installed in all other resident sleeping rooms. The facility has a capacity of 115 and had a census of 46 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for two detached buildings providing facility storage services which are each not sprinklered.	K 0000		

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	Quality Review completed on 05/17/23			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms 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 Medical	K 0321	What corrective action(s) will be accomplished for those residents	06/02/2023

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	Records office, such as a House Keeping/Bio-hazard room, 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 as many as 4 staff on the second floor. Findings include: Based on observations made during a tour of the facility with the Maintenance Director on 05/16/23 at 1:04 p.m., the corridor door to the Medical Records office located on the second floor of the facility did not have a self-closing device installed on the doorway to the corridor. This room had approximately 12 bankers' boxes full of paper medical records stored within it as well as dozens of records located throughout the Medical Records office. This office was approximately 150 square feet in size. Based on interview at the time of the observation, the Maintenance Director acknowledged that the corridor door to the Medical Records office on the second floor of the facility did not have a self-closing device installed on it, was well over 50 square feet in size, and lacked a self-closing device on the corridor door. He also added that he would have a self-closing device installed on the door as soon as ha had time to do so. This finding was reviewed with the Maintenance Director, the Regional Maintenance Director, and the facility Administrator at the exit conference on 05/15/23 at 2:05 p.m. 3.1-19(b)		found to have been affected by the deficient practice; - no residents were affected by this alleged deficient practice - the self closing device has been installed on the Medical records office door 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 same potential to be affected by this alleged deficient practice - self closing device has been installed on the medical records office door - Maintenance Director educated by the Senior executive Director on 6/2/23 on self closing devices installed on doors (see Attachment A) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - Maintenance Director educated by the Senior Executive Director on	

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			6/2/23 on self closing devices installed on doors (see Attachment A) - self closing devices installed - audits to be conducted to ensure that self closing devices are attached to all doors requiring such device (see Attachment D) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as Self closing devices (see Attachment D) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 6/2/23	
K 0374 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke			

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Bldg. 01	Barrie Subdivision of Building Spaces - Smoke Barrier Doors 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 1 of 6 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect as many as 16 residents, 4 staff and 2 visitors within the facility. Findings include: Based on observations made during a tour of the facility with the Maintenance Director on 05/16/23 at 1:04 p.m., the set of smoke barrier doors in the Administration Hall did not close completely leaving a one inch gap when the doors were tested three times. There was a one-inch gap between the doors when closed to their fullest. Based on interview during the time of observations, the Maintenance Director acknowledged these smoke barrier doors did not close completely at the time they were tested.	K 0374	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 - the gap in the smoke barrier doors has been eliminated and the doors close correctly with no gaps 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 same potential to be affected by this alleged deficient practice	06/02/2023

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	This finding was reviewed with the Maintenance Director, the Regional Maintenance Director, and the facility Administrator at the exit conference on 05/15/23 at 2:05 p.m. 3.1-19(b)		- Maintenance Director was educated by the Senior Executive Director on 6/2/23 on maintenance of smoke barrier doors (see Attachment A) - gap in smoke barrier doors in question have been corrected What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; -Maintenance Director educated by the Senior Executive Director on 6/2/23 on maintenance of smoke barrier doors (see Attachment A) - smoke barrier doors in question have been corrected - Maintenance to audit to ensure compliance (see Attachment E) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held	

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			monthly, and is overseen by the Executive Director. · CQI tool identified as Fire doors (see Attachment E) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 6/2/23	
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in			

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	accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 05/16/23 at 11:17 a.m., the weekly generator inspection documentation entitled "Direct Supply - TELS Generator testing - no load" and "Direct Supply - TELS Generator testing - under load" had missing testing documentation	K 0918	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 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 same potential to be affected by this alleged deficient practice - Maintenance Director educated by the Senior Executive Director on 6/2/23 on generator testing requirements	06/02/2023

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	January 30th to March 6th of 2023. This was a five-week period of time. Based on interview at the time of the observation, the Maintenance Director acknowledged that the above-mentioned generator inspection documents were not available for review adding that the facility was without a Maintenance Director during that period of time. This finding was reviewed with the Maintenance Director, the Regional Maintenance Director, and the facility Administrator at the exit conference on 05/15/23 at 2:05 p.m. 3.1-19(b)		- Facility hired a Maintenance Director on 4/19/23 whom has been educated on generator testing which will ensure future compliance What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - Maintenance Director educated on 6/2/23 by the Senior Executive Director on appropriate generator testing - Maintenance to conduct audits to ensure compliance (see Attachment C) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as Generator testing (see Attachment C) will be completed weekly x 4 weeks, monthly times 6 months,	

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	155029	A. BUILDING 01 B. WING	05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 6/2/23	
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 1 of 1 Executive Directors office	K 0920	What corrective action(s) will be accomplished for those residents	06/02/2023

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	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 10 residents, 6 staff and 1 visitor. Findings include: Based on observations made during a tour of the facility with the Maintenance Director on 05/16/23 at 12:24 p.m., a power strip was in use with a mini refrigerator plugged into it in the Executive Directors (EDs) office. Based on interview at the time of the observation, the Maintenance Director acknowledged the power strip was being used as an extension cord in the EDs office. This finding was reviewed with the Maintenance Director, the Regional Maintenance Director, and the facility Administrator at the exit conference on 05/15/23 at 2:05 p.m. 3.1-19(b)		found to have been affected by the deficient practice; - no residents were affected by this alleged deficient practice - the power strip in use in the Executive Directors office was removed immediately 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 same potential to be affected by this alleged deficient practice - Maintenance Director in-serviced on 6/2/23 by Senior Executive Director on appropriate power strip usage (see Attachment A) - the power strip in use in the Executive Directors office was removed immediately What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;	

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			-maintenance director in-serviced on 6/2/23 by the Senior executive Director on appropriate power strip usage (see Attachment A) - Maintenance to conduct audits to ensure compliance (see Attachment B) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as power strip usage (see Attachment B) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 6/2/23	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage			

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	Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility	K 0923	What corrective action(s) will be	06/02/2023

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	failed to ensure the door to 1 of 2 oxygen transfilling rooms was rated for at least 45-minutes. NFPA 99, Health Care Facilities Code, 2012 edition, Section 11.5.2.3.1 (1) requires oxygen transfilling rooms to be a designated area separated from any portion of a facility wherein residents are housed, examined, or treated by a fire barrier of 1-hour fire-resistive construction. A 45-minute fire-rated door is considered part of a 1-hour fire door assembly. NFPA 101, Section 8.3.3.2.3 require labels of fire door assemblies to be maintained in a legible condition. This deficient practice could affect as many as 16 residents, 4 staff, and 2 visitors within the facility. Findings include: Based on observations made during a tour of the facility with the Maintenance Director on 05/16/23 at 12:55 p.m., the door to the second-floor oxygen storage room could not have the fire rating of the door identified as the door rating sticker had been painted over and was therefore illegible. Based on interview at the time of observation, the Maintenance Director agreed that the second-floor oxygen storage room door had the door rating sticker painted over and its fire resistance rating could not be determined. This finding was reviewed with the Maintenance Director, the Regional Maintenance Director, and the facility Administrator at the exit conference on 05/15/23 at 2:05 p.m. 3.1-19(b)		accomplished for those residents found to have been affected by the deficient practice; - no residents were affected by this alleged deficient practice - door to the oxygen storage room has been corrected and has a fire rating identification 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 same potential to be affected by this alleged deficient practice - door in question has been corrected and has appropriate fire rating i.d. - Maintenance Director was educated by the Senior executive Director on 6/2/23 on doors displaying fire rating identification (see Attachment A) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;	

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			- Maintenance Director was educated by the Senior Executive Director on 6/2/23 on doors displaying fire rating identification (see Attachment A) - appropriate correction made to door - Maintenance to conduct audit to ensure compliance (see Attachment F) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as fire rating identification (see Attachment F) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 6/2/23	