STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155237	A. BUILDING -- B. WING	09/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BETHANY VILLAGE	3518 S SHELBY ST INDIANAPOLIS, IN 46227

(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: 000142 Provider Number: 155237 AIM Number: 100266940 At this Emergency Preparedness survey, Bethany Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 100 certified beds. At the time of the survey, the census was 82. Quality Review completed on 09/21/22	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/20/22 Facility Number: 000142 Provider Number: 155237 AIM Number: 100266940 At this Life Safety Code survey, Bethany Village was found not in compliance with Requirements	K 0000	K 000 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 or regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after	

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

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	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) and 410 IAC 16.2. Building 0101 and Building 0202, the Therapy Room addition constructed in 2012, were each surveyed using Chapter 19, Existing Health Care Occupancies. This one story facility was surveyed as one building of Type V(000) construction. Building 0101 was determined to be of Type V (000) construction and fully sprinklered. Building 0202 was determined to be of Type V (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 smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 100 and had a census of 82 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except for one detached storage shed. Quality Review completed on 09/21/22		October 17, 2022.	
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			

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	clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 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			

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	Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 3 of 9 exits were 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 Section 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 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Director during the initial walk through of the facility from 9:00 a.m. to 9:15 a.m. on 09/20/22, the exit door to the outside of the facility in the Main Dining Room could be opened by entering a code into a keypad at the exit door but the code was not posted at the exit door. Based on interview at the time of the observations, the Maintenance Director stated the exit door code should be posted at the exit door but agreed it was not	K 0222	1. Corrective Action: The code for opening the three identified egress doors have been posted at each of the egress doors. 2. The alleged deficient practice could have affected 20 plus residents and their visitors, 3. Staff have been in-serviced to report to a member of management, if an egress door code is not in place. 4. Monitoring: The Maintenance Supervisor/designee will monitor and ensure the codes remain posted on all egress doors. All egress doors will be monitored weekly for 4 weeks, then monthly for 5 months. In addition, this will be monitored by the QA Committee for 6 months 5. Completion Date: October 17, 2022	10/17/2022

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	posted. Based on observations with the Director of Property Management, the Field Maintenance Supervisor and the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:20 p.m. on 09/20/22, the exit door to the outside of the facility in the Main Dining Room still did not have the code posted at the keypad for the exit door. In addition, the exit door set at the main entrance to the facility and the exit door by the Social Services Office by the Clean Laundry room could also be opened by entering a code into a keypad at the exit door but the code was not posted at the exit door. The Maintenance Director entered the code into the keypad at the three exits which released the doors to open. Based on interview at the time of the observations, the Maintenance Director stated residents in the facility who have a clinical diagnosis to be in a secure wing or facility are housed in the Auguste's Cottage wing in the 400 Hall and agreed the code was not posted at the aforementioned three exit door locations. This finding was reviewed with the Executive Director, the Director of Property Management, the Field Maintenance Supervisor and the Maintenance Director during the exit conference. 3.1-19(b)			
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			

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	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 1 of over 6 hazardous areas such as laundries (larger than 100 square feet) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Clean Laundry room. Findings include: Based on observations with the Maintenance Director during the initial walk through of the facility from 9:00 a.m. to 9:15 a.m. on 09/20/22, the corridor door to the Clean Laundry room was	K 0321	1. Corrective Action: Upon discovery, the wedge that prevented the laundry room door from closing, was immediately removed and discarded. 2. The alleged deficient practice could have affected all residents, visitors, and staff. 3. All staff have been in-serviced regarding the inappropriate use of any mechanism to prevent a door from closing. In addition, staff have been instructed to report to a member of management, if they should	10/17/2022

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	propped in the fully open position with a wedge placed on the floor under the door. Based on interview at the time of the observations, the Maintenance Director agreed propping the door open with a wedge did not separate this hazardous areas from other spaces with smoke resistant partitions and doors. This finding was reviewed with the Executive Director, the Director of Property Management, the Field Maintenance Supervisor and the Maintenance Director during the exit conference. 3.1-19(b)		discover any door that is propped open. 4. The Maintenance Supervisor/designee will ensure there are no wedges placed at any door. This will be monitored daily for 4 weeks, weekly for 4 weeks, then monthly for 4 months. In addition, this will be monitored by the QA Committee for 6 months. 5. Completion Date: October 17, 2022	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review, observation and interview; the facility failed to ensure all fire alarm system initiating devices were inspected and tested in accordance with the schedules for inspection and testing frequencies in NFPA 72. 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 and Signaling Code. NFPA 72, 2010 Edition, Table 14.3.1 at 9(b) states duct detectors shall be visually inspected semiannually. NFPA 72, 2010 Edition, Table 14.4.5	K 0345	1. Corrective Action: A comprehensive inventory of the facility's duct detector system will be completed to ensure the annual inspections are completed and recorded. A tracking log will be established to ensure the annual inspections are completed. 2. The alleged deficient practice could potentially affect all residents, visitors and staff.	10/17/2022

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	at 15(a) states duct detectors shall be functionally tested annually. Section 14.6.2.1 states records shall be retained until the next test and for 1 year thereafter. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Fire Alarm Supplementary Form" documentation dated 06/24/22 with the Director of Property Management, the Field Maintenance Supervisor and the Maintenance Director during record review from 9:45 a.m. to 12:45 p.m. on 09/20/22, no duct detectors were listed as inspected or tested within the most recent twelve month period. Based on observations with the Director of Property Management, the Field Maintenance Supervisor and the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:20 p.m. on 09/20/22, one duct detector was installed on HVAC equipment in the attic near the attic access door in the restroom by the Maintenance Office. The duct detector appeared to have electrical power as a red indicator light was flashing intermittently. Based on interview at the time of the observations, the Maintenance Director agreed an operable duct detector was located in HVAC equipment in the attic at the aforementioned location. Based on interview at 2:20 p.m. on 09/20/22, the Field Maintenance Supervisor confirmed the 06/24/22 fire alarm inspection documentation did not list duct detectors as inspected or tested within the most recent twelve month period. This finding was reviewed with the Executive Director, the Director of Property Management, the Field Maintenance Supervisor and the		3. Preventative Measures: The Maintenance Supervisor will be in-serviced on the facility's duct detector system and the requirements. 4. Monitoring: A contracted vendor will complete the inspection and make recommendations as necessary. The Maintenance Supervisor/designee will review the contracted vendor's report and ensure any recommendations are reported to the Executive Director for further review and action as deemed appropriate. 5. Completion Date: October 17, 2022	

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	Maintenance Director during the exit conference. 3.1-19(b)			
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 Based on record review and interview, the facility failed to ensure a full hydrostatic flush was performed on 1 of 2 automatic sprinkler piping systems which failed a three year trip test conducted pursuant to Section 13.4.4.2.2. of NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 Edition. NFPA 25, Section 14.3.1(3) states an obstruction investigation shall be conducted for system piping whenever foreign materials are in dry pipe valves or in check valves. Section 14.3.3, states if an obstruction investigation indicates the presence of sufficient material to obstruct pipe or sprinklers, a complete flushing program shall be conducted by qualified	K 0353	1. Corrective Action: As indicated in the inspection report, the proposal for flushing the dry sprinkler system was received on 9/20/22 and will be implemented. 2. The alleged deficient practice had a potential to affect the residents, visitors, staff. 3. The recommendation for the dry system sprinkler system flush had been identified prior to this survey with plans already in place to remedy this issue. We will	10/17/2022

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	personnel. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the sprinkler system inspection contractor's "Form for Inspection, Testing and Maintenance of Dry Pipe Fire Sprinkler Systems" documentation dated 07/28/22 with the Director of Property Management, the Field Maintenance Supervisor and the Maintenance Director during record review from 9:45 a.m. to 12:45 p.m. on 09/20/22, the facility's dry sprinkler system failed the three year trip test conducted pursuant to Section 13.4.4.2.2. of NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 Edition due to the presence of debris. The "Deficiency Summary" section of the 07/28/22 inspection report stated "An obstruction investigation is recommended and due to finding debris in the system we recommend a system flush". Documentation supplied by the sprinkler system inspection contractor dated 08/31/22 indicated the dry sprinkler system was 3-year trip tested again and found it had been clogged with debris. Review of sprinkler system inspection contractor's "Sprinkler System Flush" proposal documentation dated 09/20/22 indicated "Upon reinspection on 09/15/22 it was noted that the test line clogged again and are calling for a full system flush". Based on interview at the time of record review, the Director of Property Management and the Field Maintenance Supervisor stated the three year trip testing conducted 07/28/22, 08/31/22 and 09/15/22 showed debris was clogging the line and stated the facility was awaiting a flushing proposal from the sprinkler inspection contractor which was received on 09/20/22 during the survey.		continue to correct issues as they are identified. 4. Monitoring: The Maintenance Supervisor/designee will review the vendors reports for the recommendations, report these recommendations to the Executive Director for further review and action as deemed appropriate. 5. Completion Date: October 17, 2022	

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	This finding was reviewed with the Executive Director, the Director of Property Management, the Field Maintenance Supervisor and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is			

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	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 1 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of Room 102. Findings include: Based on observations with the Director of Property Management, the Field Maintenance Supervisor and the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:20 p.m. on 09/20/22, the latching mechanism on the corridor door to resident sleeping Room 102 failed to latch into the latching plate on the door frame when the door was tested to close multiple times. Based on interview at the time of the observations, the Maintenance Director agreed the corridor door to Room 102 would not latch into the door frame to ensure the door would resist the passage of smoke. This finding was reviewed with the Executive Director, the Director of Property Management, the Field Maintenance Supervisor and the Maintenance Director during the exit conference.	K 0363	1. Corrective Action: The corridor door for room 102 will removed, repaired, if appropriate and rehung or replaced. 2. The alleged deficient practice has the potential to affect the 2 residents in room 102. 3. The Maintenance Supervisor/designee will check the corridor doors to ensure they Fully close and latch during his daily rounds. 4. Monitoring: The Maintenance Supervisor/designee will check to ensure the corridor doors close and latch, on his daily rounds for 4 weeks, weekly for 4 weeks, bi-weekly for 4 weeks then monthly for 2 months. This will be monitored by the QA Committee for 6 months. 5. Completion Date: October 17, 2022	10/17/2022

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K 0372 SS=E Bldg. 01	3.1-19(b) NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure openings through 1 of 1 ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect over 20 residents, staff, and visitors. Findings include:	K 0372	1. Corrective Action: Holes were identified during the survey in the ceiling in the closet near the Therapy exit door to the corridor near the ceiling mounted sprinkler and in the ceiling of the Shower room closet near the entrance to the Auguste's Cottage wing near the passage point of the sprinkler piping. Both holes have have been repaired. 2. This alleged deficient practice had the potential to affect 17 residents, their visitors, and staff. 3. The Maintenance Supervisor/designee will check for any breach in the ceiling smoke barriers to ensure the fire resistance rating of the smoke barriers remains intact.	10/17/2022

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	155237	A. BUILDING 01 B. WING	09/20/2022

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	Based on observations with the Director of Property Management, the Field Maintenance Supervisor and the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:20 p.m. on 09/20/22, a two inch in diameter hole was noted in the ceiling in the closet near the Therapy exit door to the corridor near the ceiling mounted sprinkler in the closet. In addition, a two inch by one inch rectangular hole was noted for the passage of sprinkler piping in the closet in the Shower Room by the entrance to the Auguste's Cottage wing. The ceiling smoke barrier in both closets was constructed of one layer of 5/8ths inch thick drywall. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned holes in the ceiling did not ensure the ceiling smoke barrier was protected to maintain the fire resistance rating of the smoke barrier. This finding was reviewed with the Executive Director, the Director of Property Management, the Field Maintenance Supervisor and the Maintenance Director during the exit conference. 3.1-19(b)		4. The Maintenance supervisor/designee will check for any breach of a smoke barrier during his daily rounds to ensure the fire resistance rating of the smoke barrier remains intact. This will be monitored weekly for 4 weeks, bi-weekly for 4 weeks, then monthly for 2 months. This will be monitored by the QA Committee. 5. Completion Date: October 17, 2022	
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 smoking materials were deposited into ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design in 1 of 2 outdoor areas where smoking was taking place. This deficient practice could affect over 2 staff and visitors in the vicinity of the outdoor staff smoking area at the kitchen exit door to the outside of the facility. Findings include: Based on observations with the Director of Property Management, the Field Maintenance Supervisor and the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:20 p.m. on 09/20/22, well over 50 cigarette butts were deposited on the ground in the exit discharge for the kitchen door to the outside of the facility. Ashtrays and metal containers with self-closing	K 0741	1. Corrective Action: The facility has provided a means of disposing of smoking materials in an outdoor area where staff smoking is taking place. The smoking materials which had previously been deposited on the ground, have ben removed and a sign has been posted instructing smokers to deposit smoking materials in the receptacle provided. 2. This alleged deficient practice could only have affected only staff as resident's do not have access to this area. 3. The Maintenance Supervisor/designee will check this smoking area for smoking materials that have not been	10/17/2022

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	cover devices into which ashtrays can be emptied of noncombustible material and safe design were not provided at this outdoor location where staff smoking was taking place. Based on interview at the time of the observations, the Maintenance Director agreed cigarette butts were not deposited into ashtrays and metal containers with self-closing cover devices at this outdoor location where staff smoking was taking place. This finding was reviewed with the Executive Director, the Director of Property Management, the Field Maintenance Supervisor and the Maintenance Director during the exit conference. 3.1-19(b)		placed in the provided receptacle. 4. The Maintenance Supervisor/designee will check this smoking area 5 days each week for 4 weeks, weekly for 4 weeks, monthly for 4 months. This will be reviewed by the QA Committee. 5. Completion Date: October 17, 2022	
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility	K 0754	1. Corrective Action: The container	10/17/2022

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	failed to ensure unattended soiled linen receptacles in 1 of 9 means of egress were stored in a room protected as a hazardous area in accordance with 19.7.5.7. This deficient practice could affect over 10 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during the initial walk through of the facility from 9:00 a.m. to 9:15 a.m. on 09/20/22, one unattended partially filled soiled linen cart was stored in the corridor outside resident Room 114 by the Clean Laundry room. Documentation imprinted on the lid of the cart indicated the cart was 55 gallon capacity. Based on observations with the Director of Property Management, the Field Maintenance Supervisor and the Maintenance Director at 1:30 p.m. on 09/20/22, the soiled linen cart was still stored in the corridor outside Room 114. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned soiled linen cart was not being stored in a room protected as a hazardous area when unattended. This finding was reviewed with the Executive Director, the Director of Property Management, the Field Maintenance Supervisor and the Maintenance Director during the exit conference. 3.1-19(b)		of soiled linen that was left unattended in the hallway for a period of time, was removed. 2. This alleged deficient practice had the potential to affect the residents, visitors and staff in the area of room 114. 3. The housekeeping/laundry staff have been in-serviced on the proper storage of soiled linen and trash containers. 4. The Maintenance Supervisor/designee will monitor for linen and trash containers improperly stored in a corridor. This will be monitored 5 days each week for 4 weeks, weekly for 4 weeks, monthly for 2 months. Managers have been in-serviced to observe for inappropriate storage in corridors. 5. Completion Date: October 17, 2022	
K 0761 SS=E Bldg. 01	Based on record review, observation and interview; the facility failed to ensure the proper operation was maintained for 2 of 2 rolling steel fire doors in accordance with NFPA 80. LSC 4.5.8	K 0761	1. Corrective Action: Kitchen rolling doors have not been replaced as suggested by the inspection contractor at the time	10/17/2022

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	requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 2010 Edition, the Standard for Fire Doors and Other Opening Protectives, Section 11.4.1.1 requires an automatic-closing device shall be installed on every rolling steel door. Section 11.4.1.2 states rolling steel doors shall close automatically upon activation or release of a fusible link or detector. Section 11.4.2.2.1 states after the automatic closing is activated, the door shall remain in the closed position until the automatic-closing device has been reset. This deficient practice could affect over 20 residents, staff and visitors in the Main Dining room. Findings include: Based on review of the rolling fire door inspection contractor's "Fire Door Drop Test" documentation dated 06/24/22 with the Director of Property Management, the Field Maintenance Supervisor and the Maintenance Director during record review from 9:45 a.m. to 12:45 p.m. on 09/20/22, the rolling fire door in the kitchen and the rolling fire door in the dish room in the kitchen both failed annual testing conducted within the most recent twelve month period. The "Deficiency Summary" section of the 06/24/22 report stated the kitchen rolling fire door passed visual inspection but failed testing. The "Deficiency Summary" section of the 06/24/22 report stated the dish room rolling fire door in the kitchen failed visual inspection and testing because "Parts are rusted-unable to test. Parts are so rusted it is not even capable of		of this survey. The replacement of two kitchen rolling doors has been approved and we are awaiting information from the contractor as to the when the doors will be available and the date the contractor will install them. 2. The alleged deficient practice has the potential to affect few residents, visitors, staff. 3. The current rolling doors continue to function. 4. The Maintenance Supervisor/designee will monitor the doors daily until new doors are installed. 5. Completion Date: October 17, 2022	

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	testing". Based on interview at the time of record review, the Director of Property Management and the Field Maintenance Supervisor stated rolling fire door repairs had not been completed and agreed rolling fire door repair documentation on or after 06/24/22 was not available for review. Based on observations with the Director of Property Management, the Field Maintenance Supervisor and the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:20 p.m. on 09/20/22, the rolling fire door inspection contractor had affixed a tag to the kitchen rolling fire door indicating the most recent inspection on the sticker was dated June 2020. The rolling fire door inspection contractor also affixed a tag to the dish room rolling fire door indicating the most recent inspection on the sticker was dated June 2019. This finding was reviewed with the Executive Director, the Director of Property Management, the Field Maintenance Supervisor and the Maintenance Director during the exit conference. 3.1-19(b)			