STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155549	A. BUILDING -- B. WING	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWBEND LIVING CENTER	7524 E JACKSON ST MUNCIE, IN 47302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/29/22 Facility Number: 000681 Provider Number: 155549 AIM Number: 100286100 At this Emergency Preparedness survey, Willowbend Living Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 60 certified beds. At the time of the survey, the census was 37. Quality Review completed on 08/31/22	E 0000		
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/29/22 Facility Number: 000681 Provider Number: 155549 AIM Number: 100286100 At this Life Safety Code survey, Willowbend	K 0000	Submission of this Plan of Correction does not constitute an admission to an agreement with facts alleged on the survey Submission of the Plan of Correction does not constitute an admission or an agreement by the provided of the truth of facts alleged or correction set forth on the statement of deficiencies.	

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

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	Living 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 one-story facility was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery-operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 60 and had a census of 37 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinkled except for two sheds used for storage which were not sprinklered. Quality Review completed on 08/31/22		The Plan of Correction is prepared and submitted because of requirements under State and Federal law. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of the Plan of Correction as our credible allegation and compliance.	
K 0100 SS=E Bldg. 02	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to maintain latching hardware on 2 of 8 smoke barrier doors room per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient	K 0100	1. No residents were affected by this alleged deficient practice however 20 residents have the potential to be affected. 2. The double doors near the ice	09/16/2022

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	practice could affect 20 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Administrator in Training on 08/29/22 between 12:15 p.m. and 2:45 p.m., the (1) set of barrier double doors near the Ice Machine Room on the "A" Hall and (2) the double barrier doors near Resident Room # 116 on the "B" Hall, did not positively latch. Based on interview during the time of observations, the double barrier doors self-closed and appeared to latch but when mild pressure was applied to one of the doors, it was evident the doors did not latch completely. This finding was acknowledged by the Maintenance Supervisor and Administrator in Training at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator present at 3:30 p.m. 3.1-19(b)		machine on A hall and the double doors near resident room 116 on b-hall have been adjusted and latch completely. 3.The facility's preventative maintenance program has been reviewed with no required changes at this time. The Maintenance Director has been re-educated regarding ensuring that latching hardware is maintained to allow for proper closure. 4. The Maintenance Director or designee will be responsible for checking doors for proper closure. This will be done on a monthly basis through the facility's preventative maintenance program. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the monthly QA meetings on an ongoing basis for a minimum of six months and the frequency of the audits will be increased or decreased according to the findings.	
K 0211 SS=E Bldg. 02	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			

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	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 interview, the facility failed to ensure 2 of over 50 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Administrator in Training on 08/29/22 between 12:15 p.m. and 2:45 p.m., the (1) Dining Room exit to the outside was obstructed with a 5-foot X 5-foot section of plexiglass. The Administrator in Training stated that the plexiglass was used several months ago as a barrier for resident visitation during the COVID 19 Pandemic. The aforementioned plexiglass was obstructing the exit discharge immediately outside the door. The Maintenance Supervisor stated he would throw it away. And (2) Resident Room #123 was equipped with a padlock requiring a key and therefore not being maintained continuously free of all obstructions or impediments to full instant use in the case of fire or other emergency. The room was being used currently for storage. This finding was acknowledged by the Maintenance Supervisor and Administrator in Training at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator present at 3:30 p.m. 3.1-19(b)	K 0211	1. There were no residents affected by this alleged deficient practice but has the potential to affect over 20 residents, staff and visitors if needing to exit the facility. 2a. The facility has removed the obstruction from the dining room exit door. 2b. The padlock was removed from room 123 and a new doorknob with a lock was put in place. A self-closing device was also placed on the door. 3.The facility's preventative maintenance program has been reviewed with no required changes at this time. The Maintenance Director has been re-educated on ensuring means of egress are continuously maintained free of all obstructions in the case of fire or other emergency. 4. The Maintenance Director or designee will be responsible for monitoring all means of egress to ensure they are maintained free of all obstructions. This will be completed daily for 4 weeks, once weekly for 4 weeks, then once monthly thereafter. Should a concern be found, immediate corrective action will occur.	09/16/2022

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			Results of these reviews and any corrective actions will be discussed during the monthly QA meetings on an ongoing basis for a minimum of six months and the frequency of the audits will be increased or decreased according to the findings.	
K 0222 SS=F Bldg. 02	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the			

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	building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall 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			
	1. Based on observation and interview, the facility failed to ensure the means of egress through the employee exit was readily accessible for residents without a clinical diagnosis requiring specialized	K 0222	1a. There were no residents or employees affected by this alleged deficient practice however over 15 staff and visitors have the potential	09/16/2022

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	security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 15, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Administrator in Training on 08/29/22 between 12:15 p.m. and 2:45 p.m., the exit door from the employee entrance/exit was marked as a facility exit, was magnetically locked and could be opened by entering a four-digit code but the code was not posted at the exit. This finding was acknowledged by the Maintenance Supervisor and Administrator in Training at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator present at 3:30 p.m. 2. Based on observation and interview, the facility failed to ensure all exterior exit doors were readily accessible and able to open on first try. This deficient practice could affect all occupants in the facility. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Administrator in Training on 08/29/22 between 12:15 p.m. and 2:45 p.m., the double door set exit doors in the Therapy Hall would not open easily on the first try when tested.		to be affected, if needing to exit the facility. 1b. There were no residents affected by this alleged deficient practice, however all occupants in the facility have the potential to be affected. 2a. The facility prominently displayed the exit code to the magnet locking door at the employee entrance/exit to ensure an easily accessible exit. 2b. The doors by the therapy room have been adjusted and a new threshold has been installed to ensure that they are readily accessible and able to open on the first try, without using excessive force. 3. The facility's preventative maintenance program has been reviewed with no required changes at this time. The Maintenance Director has been re-educated regarding ensuring that means of egress are easily accessible and doors open on the first try, without using excessive force. 4. The Maintenance Director or designee will be responsible for checking the means of egress to ensure the exits are readily accessible and that doors open on the first try, without using	

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	The Surveyor, then the Maintenance Supervisor tried to open the door, and the Maintenance Supervisor was able, after several tries and considerable effort to open the double exit doors. The Maintenance Supervisor stated that there was intention to replace the aforementioned double exit door set. This finding was acknowledged by the Maintenance Supervisor and Administrator in Training at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator present at 3:30 p.m. 3.1-19(b)		excessive force. A monitoring tool will be implemented and checked daily for two weeks, weekly for two weeks and then monthly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the monthly QA meetings on an ongoing basis for a minimum of six months and the frequency of the audits will be increased or decreased according to the findings.	
K 0271 SS=E Bldg. 02	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of 8 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect 8 staff using the Employee Exit. Findings include: Based on observations and interview during a tour of the facility with the Maintenance	K 0271	1. No residents or staff were affected by this alleged deficient practice, however 8 employees using the employee entrance/exit have the potential to be. 2. The concrete at the employee entrance/exit has been repaired to provide a level walking surface. 3.The facility's preventative	09/16/2022

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	Supervisor and Administrator in Training on 08/29/22 between 12:15 p.m. and 2:45 p.m., the exit discharge from the employee exit, used primarily as the employee entrance/exit, had large cracks in the concrete and was uneven. In varying amounts, the gaps and elevation change ranged from approximately 2-4 inches. Based on interview at the time of observation, the Maintenance Supervisor acknowledged that the walkway was in need of repair to have a complete level walking surface that was free of obstructions and trip hazards leading to the public way. This finding was acknowledged by the Maintenance Supervisor and Administrator in Training at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator present at 3:30 p.m. 3.1-19(b)		maintenance program has been reviewed with no required changes at this time. The Maintenance Director has been re-educated regarding ensuring all exits have a level walking surface, free of obstructions and are constructed of a hard packed all-weather surface. 4. The Maintenance Director or designee will be responsible for checking all exits to ensure they have a level walking surface, free of obstructions and are constructed of a hard packed all-weather surface. This will be done on a monthly basis through the facility's preventative maintenance program. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the monthly QA meetings on an ongoing basis for a minimum of six months and the frequency of the audits will be increased or decreased according to the findings.	
K 0291 SS=F Bldg. 02	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on interview and observation, it was determined that the facility failed to provide	K 0291	1. No residents, employees or visitors were affected by this	09/16/2022

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	exterior emergency lighting for all exits. LSC Section 7.9.1.1 requires emergency lighting facilities for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect all occupants in the facility including staff, visitors and residents if the facility were required to evacuate in an emergency and the generator was providing electricity at that time. This deficient practice could affect everyone in the facility. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Administrator in Training on 08/29/22 between 12:15 p.m. and 2:45 p.m., it was unknown if the exterior lights for the exit discharge for all of the facility exits were connected to the generator. The Maintenance Supervisor (who is relatively new to the facility) and the Administrator were unsure and no further verification or documentation to verify the facilities exit lighting was connected to the generator and could illuminate in the event of a power outage. This finding was acknowledged by the Maintenance Supervisor and Administrator in Training at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator present at 3:30 p.m. 3.1-19(b)		alleged deficient practice, however everyone in the facility has the potential to be affected. 2. The facility has since verified that the outside exit lighting is connected to the generator. Additionally, the facility has documented and will maintain which lights are connected to the generator to ensure compliance. 3.The facility's preventative maintenance program has been reviewed with no required changes at this time. The Maintenance Director has been re-educated regarding ensuring emergency lighting is provided at all exits. 4. The Maintenance Director or designee will be responsible for checking all exits to ensure emergency lighting is provided. This will be done once weekly for four weeks, and then on a monthly basis thereafter through the facility's preventative maintenance program. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the monthly QA meetings on an ongoing basis for a minimum of six months and the frequency of the audits will be increased or decreased according to the findings.	

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K 0293 SS=F Bldg. 02	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 1 exit signs near the Employee Lounge was marked with directional indicators to identify the direction of travel to the public way. LSC 7.10.1.2 requires exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. This deficient practice affects all residents as well as staff and visitors. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Administrator in Training on 08/29/22 between 12:15 p.m. and 2:45 p.m., the corridor exit sign near the employee lounge had the directional arrow on one side of the word, "EXIT" punched out, indicating the exit was toward the employee lounge corridor door instead of straight forward. The corridor door to the employee lounge, which the chevron points toward, had a "Not an Exit" sign affixed to the door. Based on interview at the time of observation, the Maintenance Supervisor and Administrator in Training acknowledged and stated the directional indicator was confusing.	K 0293	1. No residents were affected by this alleged deficient practice, however all residents as well as staff and visitors have the potential to be affected. 2. The facility has replaced the exit sign above the employee lounge corridor hall to indicate that the exit is straight ahead. 3.The facility's preventative maintenance program has been reviewed with no required changes at this time. The Maintenance Director has been re-educated regarding ensuring exits, other than main exterior exit doors that obviously and clearly are identifiable exits, are clearly marked by an approved sign readily visible from any direction of exit access. 4. The Maintenance Director or designee will be responsible for checking exits to ensure that they are clearly marked by an approved	09/16/2022

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	This finding was acknowledged by the Maintenance Supervisor and Administrator in Training at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator present at 3:30 p.m. 3.1-19(b)		sign readily visible from any direction of exit access. This will be done on a monthly basis through the facility's preventative maintenance program. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the monthly QA meetings on an ongoing basis for a minimum of six months and the frequency of the audits will be increased or decreased according to the findings.	
K 0321 SS=E Bldg. 02	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			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWBEND LIVING CENTER	7524 E JACKSON ST MUNCIE, IN 47302

(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
	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)			
	1. Based on observation and interview, the facility failed to maintain protection of 1 of 1 hot oil popcorn popper in the Activities room. This deficient practice could affect staff and up to 8 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Administrator in Training on 08/29/22 between 12:15 p.m. and 2:45 p.m., a hot oil popcorn popper was being stored in the Activities Office. When asked where the machine was used the activities director stated the hot oil popcorn popper was used in the Activities Room. The Activities Room did not have a self-closing device installed and is open to the corridor. The Activities Director stated that she generally closes the door, and would make the popcorn in the kitchen or outside until the room could be protected. This finding was acknowledged by the Maintenance Supervisor and Administrator in Training at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator present at 3:30 p.m.	K 0321	1a. No residents or employees were affected by this alleged deficient practice, however employees and up to 8 residents have the potential to be affected. 1b. No residents were affected by this alleged deficient practice, however more than 10 residents, as well as staff and visitors have the potential to be affected. 2a. The facility has moved the popcorn popper to the kitchen where the door is self-closing. 2b. The storage room door on 123 has been equipped with a self-closing device. 3.The facility's preventative maintenance program has been reviewed with no required changes at this time. The Maintenance Director has been re-educated regarding ensuring hazardous area doors, such as storage rooms, are provided with properly working self-closing devices.	09/16/2022

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	2. Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 10 residents, as well as staff and visitors. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Administrator in Training on 08/29/22 between 12:15 p.m. and 2:45 p.m., Room 123, greater than 50 square feet, contained several combustible items, such as, paper, plastic, and more than 70 cardboard boxes. The corridor door to this room was not equipped with a self-closing device. This finding was acknowledged by the Maintenance Supervisor and Administrator in Training at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator present at 3:30 p.m. 3.1-19(b)		4. The Maintenance Director or designee will be responsible for checking doors for proper closure. This will be done on a monthly basis through the facility's preventative maintenance program. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the monthly QA meetings on an ongoing basis for a minimum of six months and the frequency of the audits will be increased or decreased according to the findings.	
K 0324 SS=E Bldg. 02	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in			

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	smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 1. Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchen. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect staff in the kitchen and 20 residents in the dining room. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Administrator in Training on 08/29/22 between 12:15 p.m. and 2:45 p.m., the kitchen contained a UL 300 hood system and a K-class fire extinguisher with posted instructions. Based on interview, the facility's 1 Dietary Manager was asked; what is the correct response if there was a grease fire underneath the hood. The Dietary Manager replied, "grab the red extinguisher over there and use it." The employee failed to indicate activating the UL 300 hood extinguishing system and using the correct fire extinguisher for a hood grease fire. The Maintenance Supervisor stated the silver (K-Class) extinguisher should not be used for a	K 0324	1a. No residents or employees were affected by this alleged deficient practice, however kitchen employees and 20 residents in the dining room have the potential to be affected. 1b. No residents or employees were affected by this alleged deficient practice, however 6 employees and visitors have the potential to be affected. 2a. All kitchen employees have been re-educated on the use of the UL 300 hood system in the kitchen and utilizing the correct fire extinguisher for a hood grease fire. Instructions for manually operating the fire extinguishing system were posted in the kitchen. 2b. Vent panels have been ordered and will be installed by facility maintenance upon delivery. 3. The facility's preventative	09/16/2022

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	grease fire. The Maintenance Supervisor and Administrator in Training acknowledged the Dietary Manager and Maintenance Supervisors response was incorrect and that additional training would be required. This finding was acknowledged by the Maintenance Supervisor and Administrator in Training at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator present at 3:30 p.m. 2. Based on observation and interview, the facility failed to install the kitchen range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 edition, Section 6.2.4.1 states kitchen range hood system filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). This deficient practice could affect up to 6 staff and visitors. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Administrator in Training on 08/29/22 between 12:15 p.m. and 2:45 p.m., the vent panels underneath the kitchen range hood system were not installed over all the cooking appliances. Blank panels were being used and were installed over the facility's cooking range.		maintenance program has been reviewed with no required changes at this time. The Maintenance Director and Dietary Manager have been re-educated on the use of the UL 300 hood system, utilizing the correct fire extinguisher for a hood grease fire and ensuring kitchen range hood systems are installed in accordance with requirements. 4. The Maintenance Director or designee will be responsible for ensuring that kitchen employees are educated on how to use the UL 300 hood system, utilize the correct fire extinguisher for a hood grease fire, and that the kitchen range hood systems are installed in accordance with requirements. Monitoring should be completed daily for two weeks, weekly for two weeks, and then monthly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the monthly QA meetings on an ongoing basis for a minimum of six months and the frequency of the audits will be increased or decreased according to the findings.	

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	Based on interview at the time of observation, the Maintenance Supervisor and Administrator acknowledged the kitchen range hood system panels were not arranged over all the cooking appliances. This finding was acknowledged by the Maintenance Supervisor and Administrator in Training at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator present at 3:30 p.m. 3.1-19(b)			
K 0353 SS=F Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to ensure 1 of 2 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the	K 0353	1a. No residents were affected by this alleged deficient practice however all residents, staff, and visitors have the potential to be affected.	09/16/2022

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	Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Administrator in Training on 08/29/22 between 12:15 p.m. and 2:45 p.m., the facility has a supervised dry sprinkler system with 2 gauges that were dated 2015 and 2018. Based on interview at the time of the observations, the Maintenance Supervisor and Administrator in Training stated they were not aware of the outdated gauge. This finding was acknowledged by the Maintenance Supervisor and Administrator in Training at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator present at 3:30 p.m. 2. Based on observation and interview, the facility failed to ensure sprinkler heads in the laundry area were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2)		1b. No residents were affected by this alleged deficient practice however 4 employees have the potential to be affected. 1c. No residents were affected by this alleged deficient practice however 6 employees have the potential to be affected. 2a. The 2 sprinkler system gauges have been replaced by Elwood Fire. 2b. The 2 sprinklers in the laundry room have been cleaned by Elwood Fire. New Sprinklers have been ordered and will be replaced by Elwood Fire upon delivery. 2c. Ceiling panels have been installed in the kitchen closet. 3. The facility's preventative maintenance program has been reviewed with no required changes at this time. The Maintenance Director has been re-educated regarding ensuring sprinkler system gauges are replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. Additionally, the maintenance director has been re-educated on ensuring sprinkler heads are not loaded or covered with foreign material and the importance of maintaining the ceiling construction throughout the	

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	Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff and up to 4 staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Administrator in Training on 08/29/22 between 12:15 p.m. and 2:45 p.m., 2 of 5 sprinklers in the laundry area were coved in dust or showed signs of loading. This finding was acknowledged by the Maintenance Supervisor and Administrator in Training at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator present at 3:30 p.m. 3. Based on observation and interview, the facility failed to maintain the ceiling construction throughout the facility. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect 6 staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Administrator in Training on 08/29/22 between 12:15 p.m. and 2:45 p.m., in the kitchen closet which contained the gas fired water heater, the ceiling was missing, and the roof		facility. 4. The Maintenance Director or designee will be responsible for checking ceiling construction, sprinkler system gauges, and sprinkler heads. This will be done on a monthly basis through the facility's preventative maintenance program. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the monthly QA meetings on an ongoing basis for a minimum of six months and the frequency of the audits will be increased or decreased according to the findings.	

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	rafters and insulation were clearly visible. There was track along the wall in the closet providing evidence that at one time ceiling panels were used, however none were present. The sprinkler heads in the closet had no ceiling surrounding them and were hanging free from their brackets. This finding was acknowledged by the Maintenance Supervisor and Administrator in Training at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator present at 3:30 p.m. 3.1-19(b)			
K 0363 SS=E Bldg. 02	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			

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	release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 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 all 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 6 staff and 15 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Administrator in Training on 08/29/22 between 12:15 p.m. and 2:45 p.m., the following corridor doors failed to latch positively into their respective door frames: a) Clean Utility Closet on "B" Hall b) Gas Water Heater Closet in Soiled Utility room in the memory care unit, equipped with a self-closing device. c) The Kitchen Locker Room This finding was acknowledged by the	K 0363	1. There were no residents or staff affected by this alleged deficient practice however 6 employees and 15 residents have the potential to be affected. 2. The door frames to the clean utility closet on B hall, the soiled utility room on the memory care unit, and the kitchen locker room have been re-adjusted to ensure they positively latch into their respective frames. 3.The facility's preventative maintenance program has been reviewed with no required changes at this time. The Maintenance Director has been re-educated regarding ensuring all doors positively latch into their	09/16/2022

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	Maintenance Supervisor and Administrator in Training at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator present at 3:30 p.m. 3.1-19(b)		respective door frames to resist the passage of smoke. 4. The Maintenance Director or designee will be responsible for checking doors to ensure all doors positively latch into their respective door frames. This will be done on a monthly basis through the facility's preventative maintenance program. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the monthly QA meetings on an ongoing basis for a minimum of six months and the frequency of the audits will be increased or decreased according to the findings.	
K 0511 SS=E Bldg. 02	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure 1 of over 10 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault	K 0511	1a. There were no residents or employees affected by this alleged deficient practice however 4 employees have the potential to be affected. 1b. There were no residents or employees affected by this alleged	09/16/2022

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	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. (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 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		deficient practice however 20 residents on the 100 hall have the potential to be affected. 2a. The exterior outlet near the kitchen entrance has been replaced with a weatherproof junction box and cover with GFCI protection. 2b. The electrical above room 108 on the 100 hall has been replaced, and a junction box was installed. 3.The facility's preventative maintenance program has been reviewed with no required changes at this time. The Maintenance Director has been re-educated regarding ensuring receptacles within the area of the wet location have ground-fault circuit interrupter protection, and ensuring spliced electrical wires are contained inside a junction box. 4. The Maintenance Director or designee will be responsible for checking receptacles and ensuring spliced electrical wires are contained inside a junction box. This will be done on a monthly basis through the facility's preventative maintenance program. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the monthly QA meetings on an	

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	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 4 staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Administrator in Training on 08/29/22 between 12:15 p.m. and 2:45 p.m., the exterior outlet near the kitchen entrance was not provided with ground fault circuit interruption (GFCI). The Maintenance Supervisor at the time of observation stated he did not believe the receptacle was on a GFCI circuit. This finding was acknowledged by the Maintenance Supervisor and Administrator in Training at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator present at 3:30 p.m. 2. Based on observation, the facility failed to ensure 1 of 1 electrical splices were made in a junction box. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. Article 322.56 (A) states splices		ongoing basis for a minimum of six months and the frequency of the audits will be increased or decreased according to the findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155549	A. BUILDING 02 B. WING	08/29/2022

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	shall be made in listed junction boxes. This deficient practice could affect 20 residents in the 100 hall. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Administrator in Training on 08/29/22 between 12:15 p.m. and 2:45 p.m., in the 100 hall above the ceiling near Resident Room 108 there were two electrical wires spliced together using Romex that was not contained inside a junction box. Based on interview at the time of the observation, the Maintenance Supervisor acknowledged there was an electrical splice in the 100 hall above the ceiling that was not protected with a junction box stating that contractors had recently done some work in that location. This finding was acknowledged by the Maintenance Supervisor and Administrator in Training at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator present at 3:30 p.m. 3.1-19(b)			
K 0914 SS=C Bldg. 02	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at			

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	these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing at all resident rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less	K 0914	1. No residents were affected by this alleged deficient practice however all residents have the potential to be affected. 2. All electrical outlets receptacle testings have been completed and documented. 3.The facility's preventative maintenance program has been reviewed with no required changes at this time. The Maintenance Director has been re-educated regarding ensuring receptacles not listed as hospital-grade are tested at intervals not exceeding 12 months and documentation of records are maintained and associated repairs or modifications, containing date, room or area tested and results. 4. The Maintenance Director or	09/16/2022

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	than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all residents. Findings include: Based on records review and interview with the Maintenance Supervisor and Administrator on 08/29/22 between 9:30 a.m. and 11:50 a.m., an itemized listing of inspection and testing electrical outlet receptacles within the most recent twelve-month period was not available for review. Furthermore, no documentation of receptacle testing prior to January 2020 and the onset of the COVID-19 Pandemic were available for review. Based on observations with the Maintenance Supervisor and Administrator in Training during a tour of the facility each resident room contained multiple electrical receptacles installed near resident bed locations. This finding was acknowledged by the Maintenance Supervisor and Administrator in Training at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator present at 3:30 p.m. 3.1-19(b)		designee will be responsible for inspecting, testing and ensuring documentation of outlet receptacles. This will be monitored on a monthly basis through the facility's preventative maintenance program. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the monthly QA meetings on an ongoing basis for a minimum of six months and the frequency of the audits will be increased or decreased according to the findings.	