STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155702	A. BUILDING -- B. WING	10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE PERU	1850 WEST MATADOR ST PERU, IN 46970

(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: 10/31/23 Facility Number: 003130 Provider Number: 155702 AIM Number: 200386750 At this Emergency Preparedness survey, Aperion Care Peru was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 92 and had a census of 83 at the time of this survey. Quality Review completed on 11/06/23 The requirements of 42 CFR, Subpart 483.73 are Not Met as evidenced by:	E 0000		
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tammy Matthews	Administrator	12/04/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.			

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	155702	A. BUILDING -- B. WING	10/31/2023

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	*[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:			

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	(i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or			

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	(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or			

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	(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an			

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	actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required			

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	full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.			

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	(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop			

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	exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is	E 0039	**The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** **Tag number: E039** I What corrective action(s) will be accomplished for those residents found to have	11/17/2023

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	community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Maintenance Director (MD) on 10/31/23 at 02:00 p.m., no documentation of a community based or facility based annual exercise was available, but documentation of one annual tabletop exercise on 09/14/23 was available for review. Based on interview at the time of records review, the MD stated the facility did not participate in a full-scale exercise that is community-based or facility based but completed one facility based tabletop exercise within the last 12 months. This finding was reviewed with the Administrator and MD at the exit conference.		been affected by the deficient practice; **No residents were affected by this alleged deficient practice.** II How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents had the potential to be affected by this alleged deficient practice.** **The facility did participate in a facility based annual exercise but the documentation could not be located at the time of survey. Documentation has been located. Please see attached.** III What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Staff and maintenance director to be in serviced on the facility based annual exercise and documentation to be placed in emergency plan binder. New staff will be trained on the manual/mock evacuation during orientation by executive director/designee.** IV How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; /b>	

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/31/2023 Facility Number: 003130 Provider Number: 155702 AIM Number: 200386750 At this Life Safety Code survey, Aperion Care Peru 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 II222 construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and in the resident sleeping rooms. The facility has a capacity of 92 and had a census of 83 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 11/06/23	K 0000		

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K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 10 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects 10 residents. Findings include: Based on an observation during a tour of the facility with the Maintenance Director (MD) on 10/31/23 at 02:45 p.m., in the corridor to the Resident smoker exit, there were two residents in wheelchairs side by side in front of the exit doors obstructing the exit, allowing less than one foot of space to exit. Based on an interview at the time of observations, the MD agreed the wheelchairs were obstructing the Resident smoking exit in the corridor. This finding was reviewed with the Administrator and MD at the exit conference. 3.1-19(b)	K 0211	**The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** **Tag number: K211** I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents were affected by this alleged deficient practice.** II How other residents having the potential to be affected by the same deficient practice will be	11/01/2023

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APERION CARE PERU	1850 WEST MATADOR ST PERU, IN 46970

(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
			identified and what corrective action(s) will be taken; **All residents had the potential to be affected by this alleged deficient practice. Residents and staff educated on appropriate place to wait to go out for designated smoking time to ensure means of egress is not compromised.** III What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **During weekly rounds of facility by maintenance director, all means of egress will be monitored to ensure compliance and recorded the results on the QA compliance log.** IV How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; **The administrator or designee will audit the QA compliance log monthly to ensure compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make**	

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			recommendations to revise the plan of correction as indicated.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be 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			

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	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 Based on observation and interview, the facility failed to ensure the means of egress through 2 of 8 exit doors in the facility 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 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could	K 0222	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the	11/01/2023

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	affect 10 residents in the vicinity of the Library exit door and the exit door by Room 101. Findings include: Based on observation with the Maintenance Director on 10/31/23 at 02:55 and 03:20 p.m., the exit door from the Library and the exit by room 101 , both exits were in areas for residents without a a clinical diagnosis requiring specialized security measures, were marked as a facility exit, were magnetically locked, and could be opened by entering a four-digit code on the access control pad, but the code was not posted at the exit. Based on interview at the time of observation, the Maintenance Director stated the code to open the exit doors was not posted due to concern of resident elopement. The findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. **Tag number: K222** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: **No residents were affected by this alleged deficient practice.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **42 residents had the potential to be affected by this alleged deficient practice. The door codes were placed on all appropriate exit doors.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **The maintenance director will check the exit doors to ensure codes are posted at each exit door weekly and record the results on the on the QA**	

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			compliance log. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **The administrator or designee will audit the QA compliance log monthly to ensure compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
K 0223 SS=E Bldg. 01	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and			

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	* Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure 1 of 1 kitchen door to a hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2. This deficient practice could affect 40 residents in the Dining room and staff in the kitchen. Findings include: Based on observations during a tour of the facility with the Maintenance Director (MD) on 010/31/23 at 02:35 p.m., the kitchen contained over 62 gallons of trash making the kitchen a hazardous area. The door to the kitchen from the Dining Room was self-closing, but there was a kick stop engaged, not allowing the door to close. Based on interview at the time of observation, the MD agreed the kitchen door was unable to close due to the kick stop holding the door open. This finding was reviewed with the Administrator and MD at the exit conference. 3.1-19(b)	K 0223	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. **Tag number: K223** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents were affected by this alleged deficient practice.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **40 residents had the potential to be affected by this alleged deficient practice. Staff**	11/17/2023

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			educated on appropriate use of kick stop on door containing a door closure. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **During weekly rounds of facility by maintenance director, doors containing door closure will be monitored to ensure compliance and record the results on the QA compliance log.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; **The administrator or designee will audit the QA compliance log monthly to ensure compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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K 0291 SS=F Bldg. 01	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 observation and interview, the facility failed to ensure 2 of 2 battery backup lights were tested monthly and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on record review on 10/31/23 at 11:15 a.m. with the Maintenance Director (MD), the Battery Operated Emergency Light Test Log for 2023 indicated two battery operated lights located at the emergency generator location and the transfer switch location. Based on an interview at the time of record review, the MD indicated the facility has battery operated emergency exit lighting at the emergency generator and transfer switch but they are not on a monthly test and annual testing log. Based on observations during a tour of the facility with the MD on 10/31/23 from 02:25 p.m. to 03:55 p.m., the facility had 2 battery operated exit lights	K 0291	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. **Tag number: K291** I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents were affected by this alleged deficient practice.** II How other residents having the potential to be affected	11/17/2023

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	located by the emergency generator and transfer switch. The lack of monthly and annual testing of the 2 battery operated exit lights was verified by the maintenance supervisor at the time of record review and observations and acknowledged by the administrator at the exit conference on 10/31/23 at 04:10 p.m. 3.1-19(b)		by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents had the potential to be affected by this alleged deficient practice. Maintenance director updated battery operated emergency light test log monthly and annually to include the lights located at the emergency generator and the transfer switch.** III What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Maintenance will complete the battery operated emergency light test log monthly and annually to ensure compliance** IV How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; **The administrator or designee will audit the emergency light test log monthly to ensure compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA**	

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			Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0293 SS=E Bldg. 01	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 Dining room door to the outside of the facility were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 40 residents in the Dining room. Findings include: Based on observations during a tour of the facility with the Maintenance Director (MD) on 10/31/23 at 02:40 p.m., in the Dining room the South door to the outside was not an exit door and the door was	K 0293	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	11/01/2023

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	not posted with a "NO EXIT" sign. Based on interview at the time of the observation, the MD stated the Dining room south door is not an exit to the public way and acknowledged the door did not have a "NO EXIT" sign posted. 3.1-19(b)		**Tag number: K293** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents were affected by this alleged deficient practice**. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **40 residents had the potential to be affected by this alleged deficient practice. Maintenance director ordered "No Exit" sign and placed on the south door in the dining room.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **During weekly rounds by Maintenance director, all doors leading to the outside will be observed to ensure NO EXIT is posted on any door that is not an exit to the public way and record the results on the QA compliance log.** I How the corrective action(s) will be monitored to	

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			ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; **The administrator or designee will audit the QA compliance log monthly to ensure compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
K 0341 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition.	K 0341	The facility requests paper compliance for this citation.	11/03/2023

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	NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation of the fire alarm control panel with the Maintenance Director on 10/31/23 at 02:50 p.m., the time on the display of the fire alarm control panel indicated the time to be 12:38. Based on interview at the time of observation, the Maintenance Director agreed the fire alarm control panel had the wrong time and will need to be changed. The finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law **Tag number: K341** I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents were affected by this alleged deficient practice**. II How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected. Maintenance director contacted fire monitoring system and had the time updated to the correct time.**	

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			III What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Fire panel maintenance will be added to monthly preventative maintenance log to be completed by maintenance director to ensure correct time is verified. and results recorded on the QA compliance log.** IV How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; **The administrator or designee will audit the QA compliance log monthly to ensure compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing			

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	155702	A. BUILDING 01 B. WING	10/31/2023

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	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 observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet large enough to fit all spare sprinkler heads, and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility.	K 0353	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law **Tag number: K353**	11/03/2023

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	Findings include: Based on observation with the Maintenance Director on 10/31/23 at 03:35 p.m., the spare sprinkler cabinet in the riser room was not large enough to contain all sprinkler heads and prevent damage to the sprinkler heads. When the cabinet in the riser room was opened, the cabinet contained 13 sprinkler heads in protected slots and 4 sprinkler heads positioned on the shelf , not in protected slots, inside the cabinet. Based on interview at the time of the observations, the Maintenance Director agreed the cabinet was not large enough to contain all spare sprinkler heads. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents were affected by this alleged deficient practice.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents had the potential to be affected by this alleged deficient practice. All spare sprinkler heads were inspected with no concerns found and all sprinkler heads were stored appropriately to prevent any potential damage.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Spare sprinkler heads maintenance was added to the preventive maintenance log to be completed by the maintenance director and will be verified monthly and record the results on the QA compliance log.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will	

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			not recur i.e., what quality assurance program will be put into place; **The administrator or designee will audit the QA compliance log monthly to ensure compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to inspect 3 of over 20 portable fire extinguishers each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position	K 0355	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of	11/01/2023

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	(4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push to-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect 10 residents. Findings include: Based on observation during a tour of the facility with the Maintenance Director (MD) on 10/31/23 between 02:45 and 03:35 p.m., the monthly inspection tag on the fire extinguisher located in the mechanical room lacked documentation of a monthly inspections for August and September of 2023 and the fire extinguisher in Therapy lacked documentation of monthly inspections for March-September 2023. Based on interview at the time of observation, the MD confirmed the fire extinguishers located in the mechanical room and Therapy lacked the monthly inspections previously mentioned.		correction is prepared and/or executed solely because it is required by the provisions of federal and state law **Tag number: K355** I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents were affected by this alleged deficient practice**. II How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents had the potential to be affected by this alleged deficient practice. Maintenance director inspected and documented on both fire extinguishers located in the mechanical room and therapy room.** III What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **The fire extinguishers located in the mechanical room and the therapy room were added to the monthly preventative maintenance log and will be inspected monthly by**	

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	This finding was reviewed with the Administrator and MD at the exit conference. 3.1-19(b)		**Maintenance director who will also record the results on the QA compliance log** IV How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; **The administrator or designee will audit the QA compliance log monthly to ensure compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height			

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	are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 5 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect 30 residents in two smoke compartments. Findings include: Based on observation with the Maintenance Director on 010/31/23 at 03:15 p.m., the sets of smoke barrier doors by room 103 would not fully close due to the coordinating device on the door frame not correctly working. When tested, the coordinating device would hold one door open when the door without the astragal was shut first. This condition creates a one-inch gap between the doors when shut. Based on interview during the time of observations, the Maintenance Director agreed the coordinating device was not functioning properly and not allowing the doors to completely shut. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)	K 0374	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law **Tag number: K374** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents were affected by this deficient practice.** II. How other residents having the potential to be affected by the same deficient practice will be	11/03/2023

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			identified and what corrective action(s) will be taken; **25 residents had the potential to be affected by this alleged deficient practice. All barrier doors were inspected to ensure proper closure. The 1 barrier door listed on the 2567 was the only door that did not close properly and was adjusted.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **All barrier doors will be inspected monthly to ensure proper closure by the maintenance director. The results of the inspection will be documented on the preventative maintenance log and also recorded on the QA compliance log** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **The administrator or designee will audit the QA compliance log monthly to ensure compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or**	

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			greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills on each shift for 2 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on records review with the Maintenance Director (MD) on 10/31/23 at 11:30 a.m., the following shifts were missing documentation of a completed fire drill: a) A third shift fire drill in the first quarter of 2023 was not completed within the time frame (third	K 0712	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law	11/17/2023

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	shift was identified as being 10 p.m. to 6 a.m. but the drill was completed at 9 p.m.), no scenario, and signal not verified. b) The second shift fire drills in the second quarter of 2023 did not verify signal. c) The first shift fire drill in the third quarter of 2023 was not completed within the time frame (day shift was identified as being 6 a.m. to 2 p.m. but the drill was completed at 2:30 p.m. Based on interview at the time of record review, the Maintenance Director stated the drills were completed and said that the aforementioned concerns need to be corrected. 3.1-19(b)		**Tag number: 712** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents were affected by this alleged deficient practice** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by this alleged deficient practice. A fire drill with all the required components will be conducted.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **The maintenance director and maintenance assistant was inserviced on all the required components of a fire drill. Fire drills will be completed by maintenance director or maintenance assistant to include conducting fire drills on all three shifts quarterly.** IV. How the corrective action(s) will be monitored to	

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			ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **The administrator or designee will audit the fire drill log monthly to ensure all required components of a fire drill are followed.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
K 0761 SS=F Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80,	K 0761	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or	11/17/2023

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	Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include:		executed solely because it is required by the provisions of federal and state law **Tag number: 761** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents were affected by this alleged deficient practice** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by this alleged deficient practice. The fire door assemblies will be scheduled to be tested and completed prior to 11/19/23** III. What measures will be put into place and what systemic changes will be made to ensure ` that the deficient practice does not recur; **The maintenance director was inserviced on the requirement for fire door assemblies to be inspected annually. An annual fire door assembly inspection log was created and will be completed by the maintenance director.**	

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	Based on record review with the Maintenance Director (MD) on 10/31/23 documentation of an annual inspection for the fire door assemblies was available for review but was dated 10/07/22. The annual fire door inspection was past due.Based on interview at the time of records review and observation, the MD stated he was unaware that the annual fire door inspection was required. This finding was reviewed with the Administrator and MD at the exit conference. 3.1-19(b)		IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The administrator will audit the fire door assembly inspection log annually to ensure the inspection is completed annually. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating			

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	the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and interview, the facility failed to ensure non-hospital grade electrical receptacles in resident sleeping rooms were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director (MD) on 10/31/23 at 2:30 p.m., the facility's resident sleeping rooms	K 0914	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law **Tag number: K914** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents were affected by this alleged deficient practice**	11/17/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155702	A. BUILDING 01 B. WING	10/31/2023

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	contained four to eight non-hospital-grade electrical receptacles. Based on records review at 02:15 p.m., the annual electrical receptacle testing for non-hospital grade electrical receptacles was past due. The provided documentation of the last receptacle tested was dated 10/18/22. Based on interview at the time of the observation and records review, the MD confirmed all of the electrical receptacles in the resident sleeping rooms were not hospital-grade and stated annual testing per NFPA 99, Receptacle Testing requirements was past due. This finding was reviewed with the Administrator and MD at the exit conference. 3.1-19(b)		II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by this alleged deficient practice. All outlets were tested as for polarity and retention with all outlets passing and the form showing the room, location and pass/fail.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **The maintenance director was inserviced on outlet testing and the form changed to add date, room, location and pass/fail to be completed by the maintenance director or designee. Results will be recorded on the QA compliance log.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **The administrator or designee will audit the QA compliance log monthly to ensure compliance. The results of these audits will be reviewed**	

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			in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is			

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	on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 7 of 40 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect 15 residents in two smoke compartments. Findings include: Based on observations during a tour of the facility with the Maintenance Director (MD) on 10/31/23 at 03:00 and 03:05 p.m., six 'E' type oxygen cylinders were standing upright on the floor of the oxygen storage/trans-filling room and one in resident room 127 were not properly chained or supported in a proper cylinder stand or cart.	K 0923	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law **Tag number: K923** I. What corrective action(s) will be accomplished for those residents found to have been a	11/01/2023

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	Based on interview at the time of observations, the MD acknowledged six 'E' type oxygen cylinders in the oxygen storage/trans-filling room and one in resident room 127 were not properly chained or supported in a proper cylinder stand or cart. The finding was reviewed with the Administrator and the MD during the exit conference. 3.1-19(b)		affected by the deficient practice; **No residents were affected by this alleged deficient practice.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **15 residents have the potential to be affected by this alleged deficient practice. The oxygen tanks were secured appropriately.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **All the Oxygen cylinders were properly secured. The nursing staff were inserviced on proper oxygen storage. The maintenance director will make weekly rounds to ensure oxygen is properly stored and will document the results on the and also recorded on the QA compliance log** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **The administrator or designee**	

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			will audit the QA compliance log monthly to ensure compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	