| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155138 | A. BUILDING -- B. WING | 11/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| BRICKYARD HEALTHCARE - CHURCHMAN CARE CENTER | 2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203 |

| (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 |
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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 11/14/24<br><br>Facility Number: 000063<br>Provider Number: 155138<br>AIM Number: 100266210<br><br>At this Emergency Preparedness survey, Brickyard Healthcare - Churchman Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.<br><br>The facility has 115 certified beds. At the time of the survey, the census was 67.<br><br>Quality Review completed on 11/20/24 | E 0000 | | |
| K 0000<br><br>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).<br><br>Survey Date: 11/14/24<br><br>Facility Number: 000063<br>Provider Number: 155138<br>AIM Number: 100266210<br><br>At this Life Safety Code survey, Brickyard | K 0000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Thomas Johnson | Executive Director | 12/02/2024 |

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

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| | Healthcare - Churchman Care 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.<br><br>This one-story facility with a basement was determined to be of Type III (200) construction and fully sprinklered except for the bathroom in resident sleeping Room 43. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 115 and had a census of 67 at the time of this visit.<br><br>All areas where residents have customary access were sprinklered except for the bathroom in resident sleeping Room 43. All areas providing facility services were sprinklered.<br><br>Quality Review completed on 11/20/24 | | | |
| K 0161 SS=F Bldg. 01 | NFPA 101<br>Building Construction Type and Height<br><br>Based on observation and interview, the facility failed to ensure the building construction type was a permitted type as listed in Table 19.1.6.1. Table 19.1.6.1 requires a Type III(200) one story building in height to be fully sprinklered. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include: | K 0161 | K 161 Continued From page 3 K 161 Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:00 p.m. to 1:50 p.m. on 11/14/24, this one story sprinklered building was constructed of concrete block and the interior load bearing walls were wood frame. This results in a | 12/02/2024 |

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| | Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:00 p.m. to 1:50 p.m. on 11/14/24, this one story sprinklered building was constructed of concrete block and the interior load bearing walls were wood frame. This results in a construction type classification of Type III (200). Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:00 p.m. to 1:50 p.m. on 11/14/24, the bathroom for resident sleeping Room 43 was not sprinkled. Based on interview at the time of the observations, the Maintenance Director agreed the bathroom for resident sleeping Room 43 was not provided with an automatic sprinkler.<br><br>These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | | construction type classification of Type III (200). Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:00 p.m. to 1:50 p.m. on 11/14/24, the bathroom for resident sleeping Room 43 was not sprinkled. Based on interview at the time of the observations, the Maintenance Director agreed the bathroom for resident sleeping Room 43 was not provided with an automatic sprinkler.<br>1 Resident room 43 had an automatic sprinkler head added and the entire facility was audited to verify all areas have sprinkler heads.<br>2 Resident room 43 had an automatic sprinkler head added. The residents in the same smoke compartment have potential to be affected by the alleged deficient practice<br>3 An inspection task was added to tels to check the facility for sprinkler coverage every 6 months.<br>4 Maintenance director will report to QAPI no less than quarterly in perpetuity regarding life safety issues.<br>DOCUMENTATION INCLUDES RESULTS OF FULL FACILITY SPRINKLER COVERAGE AUDIT AND COMPLETED TELS TASK | |
| K 0324<br>SS=D | NFPA 101<br>Cooking Facilities | | | |

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| Bldg. 01 | Based on record review and interview, the facility failed to ensure 1 of 1 kitchen range hood exhaust system was maintained in proper working order. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition, Section 7.8.2.1(8) requires rooftop terminations to be arranged with or provided with a hinged upblast fan supplied with flexible weatherproof electrical cable and service hold-open retainer to permit inspection and cleaning that is listed for commercial cooking equipment. This deficient practice could affect over two kitchen staff.<br><br>Findings include:<br><br>Based on review of the kitchen range hood inspection contractor's "Job Service Report" dated 02/13/24 and 08/21/24 with the Maintenance Director during record review from 9:05 a.m. to 12:00 p.m. on 11/14/24, fans for the kitchen range hood need hinge kits. The "Notes" section of both inspection reports stated, "Both fans are down blast and need hinge kits installed". Based on interview at the time of record review, the Maintenance Director stated hinge kits have not been installed on or after 02/13/24.<br><br>These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | K 0324 | K 324 Continued From page 5 K 324 fans are down blast and need hinge kits installed". Based on interview at the time of record review, the Maintenance Director stated hinge kits have not been installed on or after 02/13/24<br>1 Hinge kits were installed on the kitchen hood exhaust fans.<br>2 Hinge kits were installed on the kitchen hood exhaust fans and all residents have potential to be affected by the alleged deficient practice<br>3 Upon installation Maintenance inspected the hinge kits.<br>4 No further audits are required as this is a permanent fix. Maintenance will report to QAPI no less than quarterly in perpetuity regarding life safety. | 12/02/2024 |
| K 0351 SS=E Bldg. 01 | NFPA 101<br>Sprinkler System - Installation<br><br>Based on observation and interview, the facility failed to ensure that a complete automatic | K 0351 | K 351 Continued From page 6 K 351 facility. This deficient practice | 12/02/2024 |

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| | sprinkler system was installed throughout the facility. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of resident sleeping Room 43.<br><br>Findings include:<br><br>Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:00 p.m. to 1:50 p.m. on 11/14/24, the bathroom for resident sleeping Room 43 was not sprinkled. Based on interview at the time of the observations, the Maintenance Director agreed the bathroom for resident sleeping Room 43 was not provided with an automatic sprinkler.<br><br>These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | | could affect over 10 residents, staff and visitors in the vicinity of resident sleeping Room 43. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:00 p.m. to 1:50 p.m. on 11/14/24, the bathroom for resident sleeping Room 43 was not sprinkled. Based on interview at the time of the observations, the Maintenance Director agreed the bathroom for resident sleeping Room 43 was not provided with an automatic sprinkler.<br>1 1 Resident room 43 had an automatic sprinkler head added and the entire facility was audited to verify all areas have sprinkler heads.<br>2 Resident room 43 had an automatic sprinkler head added. The residents in the same smoke compartment have potential to be affected by the alleged deficient practice<br>3 An inspection task was added to tels to check the facility for sprinkler coverage every 6 months.<br>4 Maintenance director will report to QAPI no less than quarterly in perpetuity regarding life safety issues. | |
| K 0353 SS=E Bldg. 01 | NFPA 101<br>Sprinkler System - Maintenance and Testing<br><br>Based on observation and interview, the facility | K 0353 | K 353 | 12/02/2024 |

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| | failed to ensure 1 of over 100 sprinkler heads in the facility which were painted were replaced in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states 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:<br>(1) Leakage<br>(2) Corrosion<br>(3) Physical Damage<br>(4) Loss of fluid in the glass bulb heat responsive element<br>(5) Loading<br>(6) Painting unless painted by the sprinkler manufacturer.<br>In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler.<br>This deficient practice could affect over 10 residents, staff and visitors in the vicinity of resident sleeping Room 2.<br><br>Findings include:<br><br>Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:00 p.m. to 1:50 p.m. on 11/14/24, the deflector for the ceiling mounted sprinkler installed in the closet for resident sleeping Room 2 was painted. Based on interview at the time of the observations, the Maintenance Director agreed the deflector for the aforementioned sprinkler location was painted. | | Continued From page 8 K 353<br>Director and the Maintenance Director during a tour of the facility from 12:00 p.m. to 1:50 p.m. on 11/14/24, the deflector for the ceiling mounted sprinkler installed in the closet for resident sleeping Room 2 was painted. Based on interview at the time of the observations, the Maintenance Director agreed the deflector for the aforementioned sprinkler location was painted.<br>1 The sprinkler head in resident room 2 closet was changed.<br>2 The sprinkler head in resident room 2 closet was changed. Residents in the same smoke compartment have potential to be affected by the alleged deficient practice.<br>3 A monthly Fire Sprinkler system in-house inspection was added to make sure sprinkler heads are clean and functional.<br>4 Maintenance director will report to QAPI no less than quarterly in perpetuity regarding life safety issues. | |

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| | These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | | | |
| K 0355 SS=E Bldg. 01 | NFPA 101<br>Portable Fire Extinguishers<br><br>1. Based on observation and interview, the facility failed to ensure 1 of 20 portable fire extinguishers were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. 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. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the A Wing nurse's station.<br><br>Findings include:<br><br>Based on observations with the Executive | K 0355 | K355<br>the wall mounted ABC type portable fire extinguisher located in the Pantry at the A Wing nurse's station had missing monthly inspection documentation for the most recent twelve month period. The portable fire extinguisher location was missing its normally affixed maintenance tag to document monthly and annual inspections. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned portable fire extinguisher location had missing monthly inspection documentation for the most recent twelve month period<br>1 The maintenance tag was replaced on the portable fire extinguisher in the A wing nurses station and all others were checked for appropriate tags.<br>2 The maintenance tag was replaced on the portable fire extinguisher in the A wing nurses station and all others were checked for appropriate tags. All residents in the vicinity have the | 12/02/2024 |

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| | Director and the Maintenance Director during a tour of the facility from 12:00 p.m. to 1:50 p.m. on 11/14/24, the wall mounted ABC type portable fire extinguisher located in the Pantry at the A Wing nurse's station had missing monthly inspection documentation for the most recent twelve month period. The portable fire extinguisher location was missing its normally affixed maintenance tag to document monthly and annual inspections. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned portable fire extinguisher location had missing monthly inspection documentation for the most recent twelve month period.<br><br>These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference.<br><br>3.1-19(b)<br><br>2. Based on observation and interview, the facility failed to ensure 1 of 20 portable fire extinguishers was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. | | potential to be affected by the alleged deficient practice.<br>3 A monthly inspection was added to TELS to check all fire extinguishers<br>4 Maintenance will report to QAPI no less than quarterly in perpetuity regarding life safety. | |

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| | Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the A Wing nurse's station.<br><br>Findings include:<br><br>Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:00 p.m. to 1:50 p.m. on 11/14/24, the wall mounted ABC type portable fire extinguisher located in the Pantry at the A Wing nurse's station had missing annual inspection documentation for the most recent twelve month period. The portable fire extinguisher location was missing its normally affixed maintenance tag to document an annual inspection. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned portable fire extinguisher location had missing annual inspection documentation.<br><br>These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | | | |
| K 0363 SS=E Bldg. 01 | NFPA 101<br>Corridor - Doors<br><br>Based on observation and interview, the facility failed to ensure 1 of over 50 corridor doors to resident sleeping rooms had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient | K 0363 | K363<br>Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:00 p.m. to | 12/02/2024 |

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| | practice could affect over 10 residents, staff and visitors in the vicinity of resident sleeping Room 6.<br><br>Findings include:<br><br>Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:00 p.m. to 1:50 p.m. on 11/14/24, the corridor door to resident sleeping Room 6 failed to fully close and latch into the door frame when tested to close multiple times. The latching mechanism on the door failed to protrude into the latching plate on the door frame. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned corridor door had an impediment to latching into the door frame and would not resist the passage of smoke.<br><br>These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | | 1:50 p.m. on 11/14/24, the corridor door to resident sleeping Room 6 failed to fully close and latch into the door frame when tested to close multiple times. The latching mechanism on<br>the door failed to protrude into the latching plate on the door frame. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned corridor door had an impediment to latching into the door frame and would not resist the passage of smoke.<br>1 The door latch to resident room 6 was repaired to close and latch properly.<br>2 The door latch to resident room 6 was repaired to close and latch properly. All residents within the same smoke compartment have potential to be affected by the alleged deficient practice.<br>3 A monthly door latch check task was added to TELS to check for proper door latching. Maintenance will report to QAPI no less than quarterly in perpetuity regarding life safety | |
| K 0753 SS=E Bldg. 01 | NFPA 101<br>Combustible Decorations<br><br>Based on observation and interview, the facility failed to ensure 4 of over 50 corridor doors were maintained in accordance with 19.7.5.6. 19.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: | K 0753 | K 753 Continued From page 15 K 753 Wing nurse's station. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:00 p.m. | 12/02/2024 |

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| | (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied.<br>(2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films.<br>(3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source.<br>(4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following:<br>(a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 19.7.5.6(b), (c), or (d).<br>(b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7.<br>(c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7.<br>(d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.<br>(5)*They are decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not | | to 1:50 p.m. on 11/14/24, Christmas themed wrapping paper was affixed to 60% or more of the corridor side of the three corridor doors at the A Wing nurse's station. In addition, wrapping paper was also affixed to more than 80% of the corridor side of the corridor door to the closet directly across from the A Wing nurse's station. Based on interview at the time of the observations, the Maintenance Director stated he didn't know if the wrapping paper was fire retardant, the wrapping paper was not treated with fire retardant material and agreed the affixed wrapping paper exceeded 30 percent of the face of the corridor door to aforementioned four rooms<br>1 All facility corridor doors were cleared of Christmas decorations to less than 30% of the surface area and treated with fire retardant or was completely removed.<br>2 All facility corridor doors were cleared of Christmas decorations to less than 30% of the surface area and treated with fire retardant or was completely removed.<br>3 A weekly paper audit was created to monitor and ensure staff and residents are compliant with proper fire safety regarding decorations until after the holiday season décor is completely removed. ALL STAFF WILL BE | |

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|---|---|---|---|
| | 155138 | A. BUILDING 01<br>B. WING | 11/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| BRICKYARD HEALTHCARE - CHURCHMAN CARE CENTER | 2860 CHURCHMAN AVE<br>INDIANAPOLIS, IN 46203 |

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| | present.<br>This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the B Wing nurse's station.<br><br>Findings include:<br><br>Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:00 p.m. to 1:50 p.m. on 11/14/24, Christmas themed wrapping paper was affixed to 60% or more of the corridor side of the three corridor doors at the A Wing nurse's station. In addition, wrapping paper was also affixed to more than 80% of the corridor side of the corridor door to the closet directly across from the A Wing nurse's station. Based on interview at the time of the observations, the Maintenance Director stated he didn't know if the wrapping paper was fire retardant, the wrapping paper was not treated with fire retardant material and agreed the affixed wrapping paper exceeded 30 percent of the face of the corridor door to aforementioned four rooms.<br><br>These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | | TRAINED ON PROPER HOLIDAY DÉCOR.<br>4 Maintenance will report to QAPI no less than quarterly in perpetuity regarding life safety. | |
| K 0761<br>SS=F<br>Bldg. 01 | NFPA 101<br>Maintenance, Inspection & Testing - Doors<br><br>Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be | K 0761 | K 761 Continued From page 18 K 761 documentation did not include the stairwell door to the basement by the kitchen. Based on observations with the Executive Director and the Maintenance | 12/02/2024 |

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| | permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly.<br><br>NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified:<br>(1) No open holes or breaks exist in surfaces of either the door or frame.<br>(2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.<br>(3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.<br>(4) No parts are missing or broken.<br>(5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.<br>(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.<br>(7) If a coordinator is installed, the inactive leaf closes before the active leaf.<br>(8) Latching hardware operates and secures the | | Director during a tour of the facility from 12:00 p.m. to 1:50 p.m. on 11/14/24, the stairwell door to the basement near the kitchen was equipped with a 90-minute fire resistance rating label affixed to the hinge side of the door.<br>1 A fire door inspection was conducted on the stairwell door to the basement by the kitchen.<br>2 A fire door inspection was conducted on the stairwell door to the basement by the kitchen. All residents in the adjacent area have potential to be affected by the alleged deficient practice.<br>3 A location log was sent to TELS to add all locations of the fire doors in a recurring annual inspection of the fire doors including the stairwell door to the basement by the kitchen.<br>4 Maintenance will report to QAPI no less than quarterly in perpetuity regarding life safety. | |

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| | door when it is in the closed position.<br>(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.<br>(10) No field modifications to the door assembly have been performed that void the label.<br>(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity.<br>This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of Direct Supply TELS Logbook Documentation "Inspection-Latch and Gap" documentation dated 10/22/24 with the Maintenance Director during record review from 9:05 a.m. to 12:00 p.m. on 11/14/24, annual fire door inspection documentation for all fire doors in the facility within the most recent twelve month period was not available for review. The aforementioned annual fire door inspection documentation did not include the stairwell door to the basement by the kitchen. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:00 p.m. to 1:50 p.m. on 11/14/24, the stairwell door to the basement near the kitchen was equipped with a 90-minute fire resistance rating label affixed to the hinge side of the door.<br><br>These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | | | |
| K 0914<br>SS=E<br>Bldg. 01 | NFPA 101<br>Electrical Systems - Maintenance and Testing | | | |

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| | Based on record review, observation and interview; the facility failed to ensure nonhospital-grade electrical receptacles that failed annual testing in 7 of over 50 resident rooms were replaced with hospital-grade receptacles. NFPA 70, The National Electrical Code, 2011 Edition, at Article 517.18(B) states each patient bed location shall be provided with a minimum of four receptacles. They shall be permitted to be of the single, duplex, or quadruplex type, or any combination of the three. All receptacles, whether four or more, shall be listed "hospital grade" and so identified. It is not intended that there be a total, immediate replacement of existing non-hospital grade receptacles. It is intended, however, that non-hospital grade receptacles be replaced with hospital grade receptacles upon modification of use, renovation, or as existing receptacles need replacement. This deficient practice could affect over 7 residents.<br><br>Findings include:<br><br>Based on review of "Receptacle Testing" documentation dated 08/28/24 with the Maintenance Director during record review from 9:05 a.m. to 12:00 p.m. on 11/14/24, select electrical receptacles in outlet boxes in seven resident sleeping rooms failed annual inspection and testing. Each of the receptacles which failed annual inspection and testing were listed as failing due to "Retention Force > 4 ounces". The August 2024 inspection and testing documentation did not indicate the receptacles which failed testing were replaced. In addition, the 08/28/24 "Receptacle Testing" documentation was itemized by room locations but receptacles within the room(s) were not itemized to indicate which specific receptacles were tested. The select receptacle outlet boxes in resident sleeping rooms | K 0914 | K914<br>Based on review of "Receptacle Testing" documentation dated 08/28/24 with the Maintenance Director during record review from 9:05 a.m. to 12:00 p.m. on 11/14/24, select electrical receptacles in outlet boxes in seven resident sleeping rooms failed annual inspection and testing. Each of the receptacles which failed annual inspection and testing were listed as failing due to "Retention Force > 4 ounces". The August 2024 inspection and testing documentation did not indicate the receptacles which failed testing were replaced. In addition, the 08/28/24 "Receptacle Testing" documentation was itemized by room locations but receptacles within the room(s) were not itemized to indicate which specific receptacles were tested. The select receptacle outlet boxes in resident sleeping rooms identified in the August 2024 testing as failing were located in: a. Room 24. b. Room 26. c. Room 28. d. Room 32. e. Room 37. f. Room 54. g. Room 58. Based on interview at the time of record review, the Maintenance Director stated the receptacles which failed testing have not yet been replaced. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:00 p.m. to 1:50 p.m. on | 12/02/2024 |

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| | identified in the August 2024 testing as failing were located in:<br>a. Room 24.<br>b. Room 26.<br>c. Room 28.<br>d. Room 32.<br>e. Room 37.<br>f. Room 54.<br>g. Room 58.<br>Based on interview at the time of record review, the Maintenance Director stated the receptacles which failed testing have not yet been replaced.<br>Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:00 p.m. to 1:50 p.m. on 11/14/24, outlet boxes which failed 08/28/24 testing in resident sleeping rooms 28, 54 and 58 were not hospital-grade receptacles. The other four resident sleeping rooms did not have access due to the residents being under isolation precautions due to infectious disease concerns.<br><br>These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | | 11/14/24, outlet boxes which failed 08/28/24 testing in resident sleeping rooms 28, 54 and 58 were not hospital-grade receptacles. The other four resident sleeping rooms did not have access due to the residents being under isolation precautions due to infectious disease concerns.<br>1 All resident room electrical receptacles were inspected and tested and recorded and each individual outlet was recorded. All receptacles that failed were replaced with “green dot” hospital-grade receptacles.<br>2 All resident room electrical receptacles were inspected and tested and recorded and each individual outlet was recorded. All receptacles that failed were replaced with “green dot” hospital-grade receptacles. All resident in the aforementioned rooms have potential to be affected by the alleged deficient practice.<br>3 An annual receptacle inspection and testing task was added to TELS and documentation of the inspection is required to be downloaded upon completion.<br>4 Maintenance will report to QAPI no less than quarterly in perpetuity regarding life safety. | |