STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. BUILDING -- B. WING	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE	300 N WASHINGTON ST WAKARUSA, IN 46573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/01/24 Facility Number: 000521 Provider Number: 155582 AIM Number: 100266980 At this Emergency Preparedness survey, The Waters of Wakarusa Skilled Nursing Facility was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 133 certified beds. 109 are dually certified for Medicare and Medicaid; 24 are certified for Medicare only. At the time of the survey, the census was 87. Quality Review completed on 05/08/24	E 0000	**Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Roberta	Shull Scott	05/20/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. BUILDING -- B. WING	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE	300 N WASHINGTON ST WAKARUSA, IN 46573

(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
	§485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed,			

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	155582	A. BUILDING -- B. WING	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.			
	Based on record review and interview, the facility failed to maintain an Emergency Preparedness Plan (EPP) that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and the Administrator on 05/01/24 at 10:45 a.m., The Hazardous Vulnerability Assessment (HVA) which is used to determine	E 0006	**E006**– It is the intent of the facility to ensure to maintain an emergency preparedness plan that is based on and includes a documented, facility based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73 (a) to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On	05/28/2024

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	155582	A. BUILDING -- B. WING	05/01/2024

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	facility-based and community-based risks was left blank, and no other documentation could be found regarding a risk assessment utilizing the all-hazards approach. Based on an interview at the time of record review, the Maintenance Director and the Administrator stated a risk assessment utilizing an all-hazards approach was not completed. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference.		_____05/11/2024_____ the Maintenance Supervisor, DON and the Administrator filled out the hazardous vulnerability assessment and documented the information in the facilities Emergency Preparedness binders located at the nurse's station and all other areas to meet set standards. The Administrator verified the work _____05/11/24 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On ___05/23/2024_____ the Administrator Inserviced the Maintenance Supervisor/DON/designee on the requirement that a hazardous vulnerability assessment must be filled out and documented in the facilities Emergency Preparedness binders located at the nurse's station and all other areas to meet set standards. b On ___05/23/2024_____ the Administrator/Maintenance Supervisor/DON Inserviced all staff on the updated Emergency Preparedness binders located at the nurses station and all other areas to meet set standards. c The Maintenance Supervisor/DON/Administrator/des	

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			ignee will ensure a hazardous vulnerability assessment must be filled out and documented in the facilities Emergency Preparedness Binder to meet set standards. d The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The Administrator and Maintenance Supervisor/DON/designee will review the Emergency Preparedness Policy Manual and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. Results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.** **Our date of compliance is ____5/28/2024_____.**	

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E 0031 SS=C Bldg. --	403.748(c)(2), 416.54(c)(2), 418.113(c)(2), 441.184(c)(2), 482.15(c)(2), 483.475(c)(2), 483.73(c)(2), 484.102(c)(2), 485.625(c)(2), 485.68(c)(2), 485.727(c)(2), 485.920(c)(2), 486.360(c)(2), 491.12(c)(2), 494.62(c)(2) Emergency Officials Contact Information §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff.			

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	(ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff (ii) The State Licensing and Certification Agency (iii) The Office of the State Long-Term Care Ombudsman (iv) Other sources of assistance in accordance with 42 CFR 483.73(c) (2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and the Administrator on 05/01/24 at 10:55 a.m., the provided forms for Federal, State, and Tribal emergency contacts were left blank. This included The State Licensing and Certification Agency, The Office of the State Long-Term Care Ombudsman, and other sources of assistance. Based on an interview at the time of record review, the Maintenance Director and the Administrator agreed the emergency contact list was no filled out. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference.	E 0031	**E031** – It is the intent of the facility to ensure the emergency preparedness communication plan includes contact information for the following: federal, State, tribal, regional or local emergency preparedness staff, the state licensing and certification agency, the office of the state long term care ombudsman, other sources of assistance in accordance with 42 CFR 483.73©(2) to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 5/11/2024 the Administrator and the Maintenance Supervisor/designee reviewed and updated the emergency preparedness communication plan includes 2 contact information for the following: 1. Federal, state, tribal, regional, or local emergency preparedness staff, 2.the state licensing and certification agency 3. The office of the state long term care ombudsman 4. Other sources of assistance in accordance with 42 CFR 483.73(c) to meet set standards. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to	05/28/2024

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			be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 5/23/2024 the Administrator Inserviced the DON/Maintenance Supervisor/designee on the requirement to ensure to review and update the emergency preparedness communication plan includes 2 contact information for the following: 1. Federal, state, tribal, regional, or local emergency preparedness staff, 2.the state licensing and certification agency 3. The office of the state long term care ombudsman 4. Other sources of assistance in accordance with 42 CFR 483.73(c) to meet set standards. b DON/Maintenance Supervisor/designee will work with the Administrator to ensure to review and update the emergency preparedness communication plan includes 2 contact information for the following: 1. Federal, state, tribal, regional, or local emergency preparedness staff, 2.the state licensing and certification agency 3. The office of the state long term care ombudsman 4. Other sources of assistance in accordance with 42 CFR 483.73(c) to meet set standards. If any issues are discovered, they will be addressed and resolved immediately. c The Administrator will monitor adherence to the	

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			Emergency Preparedness Policy Manual and validate the documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a At least annually to ensure compliance, the Administrator and DON/Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual and conduct required exercises and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. Results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/28/2024 _____.**	
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).	K 0000	**Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an**	

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	Survey Date: 05/01/24 Facility Number: 000521 Provider Number: 155582 AIM Number: 100266980 At this Life Safety Code survey, The Waters of Wakarusa Skilled Nursing Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 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. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridors. 73 resident rooms were provided with battery operated smoke detectors. The facility is partially protected by a diesel-powered 230 kW emergency generator. The facility has 133 certified beds. 109 are dually certified for Medicare and Medicaid; 24 are certified for Medicare only. At the time of the survey, the census was 87. Quality Review completed on 05/08/24		**admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
K 0131 SS=E Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing,			

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	treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 Based on observation and interview, the facility failed to ensure 1 of 1 occupancy separation fire doors were self-closing and latch into the frame. LSC 8.3.3.3 states unless otherwise specified, fire doors shall be self-closing/latching or automatic-closing in accordance with 7.2.1.8. This deficient practice could affect all 25 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 05/01/24 at 12:31 a.m., the fire door that separated Healthcare from Assisted Living was self-closing but did not latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director stated the separation fire door was rubbing on the door frame and would not self-latch. The findings were reviewed with the Administrator and Maintenance Director during the exit conference.	K 0131	**K131**– It is the intent of the facility to ensure occupancy separation fire doors are self-closing and latch into the frame to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On _5/21/2024 the Maintenance Supervisor/designee repaired the fire door that separated healthcare from assisted living to ensure itself closes and latches into the frame to meet set standards. The Administrator verified the repair on __5/23/2024 . **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. On 05/21/2024. the Maintenance Supervisor/designee inspected all other areas and found no other	05/28/2024

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	3.1-19(b)		negative findings. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 05/23/204 the Administrator Inserviced the Maintenance Supervisor on the requirement to ensure to provide fire doors that would limit the spread of fire and to ensure they self-close and latch fully into the frame to meet set standards. b Maintenance Supervisor/designee will inspect all doors throughout the facility monthly to ensure they would limit the spread of fire and to ensure they close and latch as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly	

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			Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 05/28/2024 _____.**	
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition. 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:	K 0345	**K345**– It is the intent of the facility to ensure fire alarm systems are continuously in proper operating condition to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 05/03/2024 the Maintenance Supervisor/designee corrected the time on the fire alarm control panel to meet set standards. The Administrator	05/28/2024

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WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE	300 N WASHINGTON ST WAKARUSA, IN 46573

(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
	Based on observation of the fire alarm control panel with the Maintenance Director on 05/01/24 at 1:03 p.m., the time on the fire alarm control panel indicated the time as 1:53 p.m. when checked at 1:03 p.m. Based on interview at the time of observation, the Maintenance Director agreed the fire alarm control panel had the wrong time. The finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		verified the work on 05/03/2024 _____ . 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On __ 05/23/2024 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure fire alarm systems are continuously in proper operating condition and the fire alarm control panel displays the correct time to meet set standards. b Maintenance Supervisor/designee will ensure fire alarm systems are continuously in proper operating condition and the fire alarm control panel displays the correct time as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.	

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			4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.** **Our date of compliance is** _____ 05/28/2024 _____**.**	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____			

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	c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to maintain 1 of 1 automatic sprinkler systems. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 5.3.4.1.2 states the concentration of antifreeze solution shall be limited to the minimum necessary for the anticipated minimum temperature. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of the facility's annual sprinkler system inspection report with the Maintenance Director and Administrator on 05/01/24 at 09:57 a.m., the annual sprinkler report dated 12/20/23 showed the low testing point for the antifreeze was -3 degrees Fahrenheit. The reference section in NFPA Annex Figure A.5.3.4.1 Isothermal Lines - Lowest One-Day Mean Temperature (Fahrenheit.) showed the mean lowest temperature for the facility was at -10 Fahrenheit. Based on an interview at the time of record review, the Maintenance Director agreed the antifreeze was tested at -3 degrees and stated the facility location can get below -3 degrees in the winter.	K 0353	**K353**– It is the intent of the facility to ensure to maintain the automatic sprinkler systems to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On 05/20/2024 the facilities licensed sprinkler contractor adjusted the freeze protection on the sprinkler system to meet set standards. The Administrator verified the work on ____ 05/20/2024 ____. **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. **3 MEASURES TO PREVENT REOCCURRENCE**: a On _____ 05/23/2024 _____ the Administrator Inserviced the Maintenance Supervisor/designee on the requirement to ensure to maintain the sprinkler systems and ensure the low testing point for the antifreeze is -10 Fahrenheit to meet set standards. b Maintenance Supervisor/designee will ensure that the facilities licensed sprinkler contractor will maintain the freeze protection on the sprinkler system	05/28/2024

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	The findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		as a part of the facility's quarterly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is** 05/28/2024**.**	

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K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observations, records review, and interview, the facility failed to ensure 2 of 8 smoke barrier walls were constructed to requirements according to the authority having jurisdiction (AHJ). LSC 8.2.3.1 states the fire resistance of structural elements and building assemblies shall be determined in accordance with test procedure set forth in ASTM E 119, Standard Test Methods for Fire Tests of Building Construction and Materials, or ANSI/UL 263, Standard for Fire Tests of Building Construction and Materials; other approved test methods; or analytical methods approved by the AHJ. The AHJ requires penetrations in smoke barriers to be sealed with a firestop system or device tested in accordance with ASTM E 814, Standard Test Method for Fire-Tests of Through-Penetration Fire Stops. This deficient practice could affect 35 residents in three smoke compartments. Findings include:	K 0372	**K372**– It is the intent of the facility to ensure smoke barrier walls are constructed to requirements according to the authority having jurisdiction (AHJ) to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On **_05/21/2024_____** the Maintenance Supervisor/designee sealed the penetrations above the ceiling tiles the smoke barrier walls to peach hall and by exit #7 with a one-hour fire rated material to meet set standards. The Administrator verified the work on _____ 5/23/202 _____ . **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to	05/28/2024

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	Based on observation during a tour of the facility with the Maintenance Director on 05/01/24 between 1:15 p.m. and1:45 p.m., above the ceiling tiles the smoke barrier walls to Peach Hall and by Exit #7 contained penetrations filled with drywall joint compound. Based on records, there was no documentation to show the joint compound meets ASTM E 814. Based on an interview at the time of observation, the Maintenance Director stated the joint compound is not fire rated and will replace it with fire caulk. The finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		be affected but none were. On _____ 05/21/2024 _____ the Maintenance Supervisor/designee inspected all smoke barrier walls and ceilings throughout the facility for penetrations and found no other negative findings. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 05/23/2024 _____ the Administrator in serviced the Maintenance Supervisor/designee on the requirement that smoke barriers walls and ceilings are constructed to provide at least a one hour resistance rating and must be free from penetrations to meet set standards. b Maintenance Supervisor/designee will inspect all smoke barrier walls and ceilings throughout the facility monthly to ensure they remain free of penetrations as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4 MONITORING**	

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			CORRECTIVE ACTION: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.** **Our date of compliance is 05/228/2024**	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances,			

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	secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on observation, records review, and interview, the facility failed to enforce 1 of 1 non-smoking policies. This deficient practice could affect 15 residents using exit #7 for evacuation. Findings include: Based on observations with the Maintenance Director on 05/01/24 at 12:19 p.m., smoking on property was evident due to at least 15 cigarette butts on the outside of exit door #7. Based on records review at 11:00, the smoking policy stated smoking is not allowed on the facility's property. Based on interview at the time of observation and records review, the Maintenance Director stated the facility is a non-smoking campus and confirmed there was smoking on property due to the cigarette butts on the ground outside exit #7. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)	K 0741	**K741** – It is the intent of the facility to ensure to enforce nonsmoking policies to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 05/11/2024_____ the Administrator/Housekeeping Supervisor/ Maintenance Supervisor removed the cigarette butts from the property to meet set standards. The Administrator verified the work on 05/23/2024 . 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 05/23/2024 the Administrator/Maintenance/DON will ensure the facility adheres to the smoking policy and procedures to meet set standards.	05/28/2024

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			b Maintenance Supervisor/Administrator/DON/Housekeeping Supervisor/designee will conduct weekly inspections on the property to ensure the Smoking policy and procedures are being followed. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Smoking Policy and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is**	

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K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage/transfer rooms was provided with a sign indicating that transferring is occurring. NFPA 99 11.5.2.3.1(3) states, the area is posted with signs indicating that trans-filling is occurring and that smoking in the immediate area is not permitted. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director on 05/01/24 at 12:59 p.m., the oxygen transfilling room contained liquid oxygen tanks. The door to the room was not provided with sign that indicates when transfilling of liquid oxygen is occurring. Based on interview at the time of observation, the Maintenance Director stated there was not a sign that indicates when transfilling of liquid oxygen is occurring.	K 0927	**K927**– It is the intent of the facility to ensure liquid oxygen storage/transfer rooms are provided with a sign indicating that transferring is occurring to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 05/20/2024 _____ the Maintenance Supervisor/DON/designee installed signage on the liquid oxygen storage/transfer rooms to indicate when transferring is occurring to meet set standards. The Administrator verified the work on _____ 05/23/2024 _____ . 2 **ALL OTHERS WITH POTENTAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were.	05/28/2024

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	This finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		3 **MEASURES TO PREVENT REOCCURRENCE**: a On 05/23/2024 the Administrator Inserviced the DON/ Maintenance Supervisor/designee that we will have the proper signage in place when oxygen transferring is occurring to meet set standards. b On 05/23/2024 _____ the Administrator/DON/ Maintenance Supervisor/designee Inserviced all nursing staff on the oxygen policy and procedures including the proper signage for when the oxygen transferring is occurring to meet set standards. c The Administrator will monitor adherence to the Oxygen Policy & Procedures including liquid oxygen transferring signage is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the DON/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction**	

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			constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is _____ 05/28/2024 _____**.**	