STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155389	A. BUILDING -- B. WING	04/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(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: 04/03/23 Facility Number: 000473 Provider Number: 155389 AIM Number: 100290410 At this Emergency Preparedness survey, Westpark A Waters Community was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 89 certified beds. At the time of the survey, the census was 38. Quality Review completed on 04/11/23	E 0000	The following Plan of Correction constitutes the facility's written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission to and does not constitute an agreement with alleged deficiencies herein. The Plan of Correction is submitted to meet the requirements established by the state and federal regulations. The facility requests a desk review.	
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: 04/03/23 Facility Number: 000473 Provider Number: 155389 AIM Number: 100290410 At this Life Safety Code survey, Westpark A	K 0000	The following Plan of Correction constitutes the facility's written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission to and does not constitute an agreement with alleged deficiencies herein. The Plan of Correction is submitted to meet the requirements established by the state and federal regulations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kesha LaGrone	HFA	04/18/2023

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.

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	Waters Community 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 consisted of two sections: the original section determined to be Type III (200) construction and an addition, built in 2003 was determined to be Type V (000) construction. The facility is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The entire facility was surveyed as Type V (000) construction. The facility has a capacity of 89 and had a census of 38 at the time of this visit. All areas where the residents have customary access were sprinklered. The facility has two detached storage sheds which were not sprinklered. Quality Review completed on 04/11/23		The facility requests a desk review.	
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 1 of 4 corridor door sets would	K 0100	**K100**– It is the intent of the facility to ensure corridor door sets would	04/19/2023

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	self-close and latch into the door frame per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 20 residents, staff, and visitors in the vicinity of the corridor door set by Room 6. Findings include: Based on observations with the Maintenance Assistant during a tour of the facility from 9:05 a.m. to 11:20 a.m. on 04/03/23, the west door in the corridor door set by Room 6 was held in the fully open position with a magnetic hold open device set to release with fire alarm system activation, latching hardware and a self-closing device but the door failed to self-close and latch into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Maintenance Assistant agreed the west door in the door set by Room 6 would not fully self-close and latch into the door frame. This finding was reviewed with the Executive Director, the Maintenance Director, and the Maintenance Assistant during the exit conference. 3.1-19(b)		self close and latch into the door frame per 4.6.12.3 to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 4/18/2023 the Maintenance Supervisor/designee made repairs to the west door in the corridor door set by Room 6 to ensure the door fully self closes and latches into the door frame to meet set standards. The Administrator verified the work on 4/18/2023. 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 4/18/2023 the Maintenance Supervisor/designee inspected all corridor doors throughout the facility and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 4/18/2023 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that corridor doors must fully self close and latch into the frame to meet set standards. b. Maintenance Supervisor/designee will inspect all corridor doors throughout the facility monthly to ensure they fully self close and latch into the frame as a part of the facility's Preventive Maintenance Program	

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			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 4/19/2023.**	
K 0291 SS=F	NFPA 101 Emergency Lighting			

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Bldg. 01	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 1 of 8 battery powered emergency lighting systems was maintained in accordance with LSC Section 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70, National Electric Code. This deficient practice could affect all residents, staff and visitors if needing to exit the facility from the main entrance lobby. Findings include: Based on observations with the Maintenance Assistant during a tour of the facility from 9:05 a.m. to 11:20 a.m. on 04/03/23, the battery-operated lighting system affixed to the wall above the door set in the main entrance lobby failed to illuminate when its respective test button was pushed multiple times. Based on interview at the time of the observations, the Maintenance Assistant agreed the aforementioned battery powered emergency lighting system failed to illuminate when its respective test button was pushed multiple times. This finding was reviewed with the Executive Director, the Maintenance Director, and the Maintenance Assistant during the exit conference. 3.1-19(b)	K 0291	**K291** – It is the intent of the facility to ensure battery powered emergency lighting systems are maintained in accordance with LSC Section 7.9 to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 4/18/2023 the Maintenance Supervisor/designee repaired the exit light affixed to the wall above the door set in the main entrance lobby to ensure it is working to meet set standards. The Administrator verified the testing on 4/18/2023 . **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 4/18/2023 the Administrator inserviced the Maintenance Supervisor/designee on the requirement to provide and maintain exit lighting including illumination to meet set standards. 2.Maintenance Supervisor/designee will provide and maintain exit lighting monthly including proper illumination as a part of the facility's Preventive Maintenance Program and	04/19/2023

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			document those tests on the Battery-Operated Exit Lights and signs Inspection Log and will maintain emergency lighting to meet set standards. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.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 4/19/2023.**	

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K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 3 of over 8 hazardous areas such as combustible storage areas (over 50 square feet in size) and fuel fired heater rooms were separated from other spaces by smoke resistant partitions	K 0321	**K321**– It is the intent of the facility to ensure hazardous areas such as combustible storage area (over 50 square feet in size) and fuel fired heater rooms are separated	04/19/2023

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	and doors. Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 9:05 a.m. to 11:20 a.m. on 04/03/23, the following was noted: a. the active door leaf in the corridor door set to the Central Supply Room was equipped with a self-closing device but the door failed to fully self-close and latch into the door frame when tested to close multiple times. The room was used to store combustible boxes and supplies and was larger than 50 square feet in size. b. a 3/4ths inch gap was noted between the face of the door and the door stop near the floor for the corridor door to the Maintenance Room by the Med Prep/Oxygen Room by the west nurse's station when the door was in the fully closed and latched position. The room contained two natural gas fired water heaters. c. an eight inch by eight-inch hole was noted in the wall of the Laundry Utilities Room just above the wall mounted outlet box which was broken and missing its cover plate. A long rectangular hole was also noted in the wall just below the same outlet box. The room contained four natural gas fired water heaters. Based on interview at the time of the observations, the Maintenance Director and the Maintenance Assistant agreed the aforementioned hazardous areas were not separated from other spaces by smoke resistant partitions and doors. This finding was reviewed with the Executive		from other spaces by smoke resistant partitions and doors to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 4/18/2023 the Maintenance Supervisor/designee repaired the self closing device on the active door leak in the corridor door set to the Central Supply Room to ensure door self closes and latches into the frame to meet set standards. The Administrator verified the work on 4/18/2023 . b. On 4/18/2023 the Maintenance Supervisor/designee repaired the ¾" gap with an approved fire rated material on the corridor door to the Maintenance Room by the Med Prep/Oxygen Room by the west nurse's station to meet set standards. The Administrator verified the work on 4/18/2023 . c. On 4/18/2023 the Maintenance Supervisor/designee 1) repaired the eight inch by eight inch hole with a one hour fire rated material in the wall of the laundry utilities room 2) Installed a new wall mounted outlet box and cover plate 3) repaired the hole with a one hour fire rated material in the wall just below the same outlet box to meet set standards. The Administrator verified the work on 4/18/2023 . **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff	

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	Director, the Maintenance Director, and the Maintenance Assistant during the exit conference. 3.1-19(b)		and visitors have the potential to be affected but none were. On 4/18/2023 the Maintenance Supervisor/designee inspected all hazardous areas for holes and self-closing devices and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 4/18/2023 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that all hazardous areas remain free of holes/penetrations and must have self-closing devices to meet set standards. b. Maintenance Supervisor/designee will inspect all hazardous area doors throughout the facility monthly to ensure they remain free of holes/penetrations and have self closing devices 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 4/19/2023.**	
K 0351 SS=F Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms			

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	where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction in 5 of over 50 rooms in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 9:05 a.m. to 11:20 a.m. on 04/03/23, the following ceiling mounted sprinkler locations were missing its escutcheon: a. in the copier room by the Accounting Department Office near the main entrance lobby. b. in the closet in Room 8. c. in the Equipment/Server room by the restroom near the main entrance lobby. d. in the Women's restroom by the Scheduler/Medical Records Office. e. in the closet in Room 45. Based on interview at the time of the observations, the Maintenance Director and the Maintenance Assistant agreed the aforementioned ceiling mounted sprinkler locations had missing escutcheons. This finding was reviewed with the Executive	K 0351	**K351** - It is the intent of the facility to ensure to maintain the ceiling construction in rooms in accordance with NFPA 13, Standard for the installation of sprinkler systems to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On 4/18/2023 the Maintenance Supervisor/designee installed the missing escutcheon rings on the ceiling mounted sprinklers in the following locations: 1) in the copier room by the Accounting Department Office near the main entrance lobby 2) in the closet in room 8 3) in the equipment/server room by the restroom near the main entrance lobby 4) in the women's restroom by the scheduler/medical records office 5) in the closet in room 45 to meet set standards. The Administrator verified the installation on 4/18/2023 . **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**:	04/19/2023

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	Director, the Maintenance Director, and the Maintenance Assistant during the exit conference. 3.1-19(b)		a. On 4/18/2023 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that ceiling mounted sprinkler locations must be maintained including the escutcheon ring installed to meet set standards. b. A Certified sprinkler contractor/Maintenance Supervisor/designee will inspect all sprinkler heads monthly to ensure they are maintained and have the escutcheon ring installed 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. **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.	

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			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 4/19/2023.**	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25,	K 0353	**K353** – It is the intent of the facility to ensure sprinkler systems are in accordance with LSC 9.7.5 and to ensure to maintain the ceiling construction	04/19/2023

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WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

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	Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Section 5.2.2.2 requires sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect all occupants. Findings include: Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 9:05 a.m. to 11:20 a.m. on 04/03/23, blue data cables were laying on top of horizontal sprinkler piping in the attic above the corridor ceiling as observed from the attic access door outside Room 7. Based on interview at the time of the observations, the Maintenance Director and the Maintenance Assistant agreed sprinkler piping was used to support non-system components in the attic near Room 7. This finding was reviewed with the Executive Director, the Maintenance Director, and the Maintenance Assistant during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the ceiling construction in 2 of over 50 rooms. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of		in rooms to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 4/18/2023 the Maintenance Supervisor removed the blue data cables that were laying on top of horizontal sprinkler piping in the attic above the corridor ceiling as observed from the attic access door outside room 7 to meet set standards. The Administrator verified the work on 4/18/2023 . 2.On 4/18/2023 the Maintenance Supervisor/designee realigned the two suspended ceiling tiles in the laundry utilities room that were misaligned in the ceiling tile grid to meet set standards. The Maintenance Supervisor/designee sealed the six inch hole with a one hour fire rated material that was noted in a ceiling tile in the room for the passage of a red water line through the ceiling tile to meet set standards. The Maintenance Supervisor/designee repaired the six inch by one inch hole with a one hour fire rated material that was noted in a ceiling tile in the closet in room 45 to meet set standards. The Administrator verified the work on 4/18/2023 . **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were.	

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	sprinkler and the type of construction. This deficient practice could affect over 20 residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 9:05 a.m. to 11:20 a.m. on 04/03/23, two suspended ceiling tiles in the Laundry Utilities room were misaligned in the ceiling tile grid which did not maintain the ceiling construction. A six-inch hole was also noted in a ceiling tile in the room for the passage of a red water line through the ceiling tile. In addition, a six inch by one inch hole was noted in a ceiling tile in the closet in Room 45. Based on interview at the time of the observations, the Maintenance Director and the Maintenance Assistant agreed ceiling tiles were not properly aligned in the ceiling tile grid or had holes in the tiles at the aforementioned locations. This finding was reviewed with the Executive Director, the Maintenance Director, and the Maintenance Assistant during the exit conference. 3.1-19(b)		**3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 4/18/2023 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that the sprinkler system must be properly maintained including no items resting on the pipes and to ensure ceiling construction is maintained including no penetrations to meet set standards. 2.Maintenance Supervisor/designee will ensure the sprinkler systems are properly maintained including no items resting on the pipes and to ensure ceiling construction is maintained including no penetrations 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. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the	

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			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 4/19/2023.**	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping			

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	the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 47 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 practice could affect over 10 residents, staff, and visitors in the vicinity of resident sleeping Room 5. Findings include: Based on observations with the Maintenance Assistant during a tour of the facility from 9:05 a.m. to 11:20 a.m. on 04/03/23, the corridor door to resident sleeping Room 5 failed to latch into the door frame when tested to close multiple times. The latching mechanism on the door would not protrude into the latching plate on the door frame. Based on interview at the time of the observations, the Maintenance Assistant agreed	K 0363	**K363** – It is the intent of the facility to ensure corridor doors to resident sleeping rooms have no impediment to closing and latching into the door frame and would resist the passage of smoke to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On 4/18/2023 the Maintenance Supervisor/designee repaired the latching mechanism in the corridor closet door to resident sleeping room 5 so it latch fully into the frame to meet set standards. The Administrator verified the repairs on 4/18/2023 . **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**:	04/19/2023

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	the aforementioned corridor door had an impediment to closing and latching into the door frame and would not resist the passage of smoke. This finding was reviewed with the Executive Director, the Maintenance Director, and the Maintenance Assistant during the exit conference. 3.1-19(b)		a. All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee inspected all corridor doors to ensure they latch fully into the frame and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 4/18/2023 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that corridor doors latch fully into the frame to meet set standards. b. Maintenance Supervisor/designee will inspect all corridor doors throughout the facility monthly to ensure they latch fully into the frame 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	

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			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 4/19/2023.**	
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 observation and interview, the facility failed to ensure openings through 1 of 1 ceiling smoke barriers was protected to maintain the fire	K 0372	**K372** – It is the intent of the facility to ensure openings through ceiling smoke barriers are	04/19/2023

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	resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes, and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect over 10 residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 9:05 a.m. to 11:20 a.m. on 04/03/23, a hole was noted in the ceiling of the Janitor's closet by the west nurse's station and in the corridor ceiling outside the Maintenance Director's Office by the west nurse's station. The hole in the ceiling was next to the escutcheon for the ceiling mounted sprinkler at each location. Based on interview at the time of the observations, the Maintenance Director and the Maintenance Assistant agreed the aforementioned openings did not ensure the ceiling smoke barrier was protected to maintain the fire resistance rating of the smoke barrier. This finding was reviewed with the Executive Director, the Maintenance Director, and the Maintenance Assistant during the exit conference. 3.1-19(b)		protected to maintain the fire resistance rating of the smoke barrier to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 4/18/2023 the Maintenance Supervisor/designee repaired the hole with a one hour fire rated material that was noted in the ceiling of the Janitor's closet by the west nurse's station and in the corridor ceiling outside the maintenance director's office by the west nurse's station to meet set standards. The Administrator verified the repairs on 4/18/2023 . 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 4/18/2023 the Maintenance Supervisor/designee inspected all ceiling smoke barriers throughout the facility for penetrations and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 4/18/2023 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that ceiling smoke barriers must be maintained and must be free of penetrations to meet set standards. b. Maintenance Supervisor/designee will inspect all ceiling smoke barriers and ensure they are maintained and	

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			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 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 4/19/2023.**	

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K 0500 SS=F Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 4 of 5 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 9:05 a.m. to 11:20 a.m. on 04/03/23, the following four water heaters each had expired Certificate of Inspection documentation from the State of Indiana: a. the service water heater identified as IN321485. b. the service water heater identified as IN321956. c. the service water heater identified as IN321957. d. the service water heater identified as IN321958. Based on interview at the time of the observations, the Maintenance Director stated current Certificate of Inspection documentation was not available for review and agreed the aforementioned service water heaters each had expired Certificate of Inspection documentation from the State of Indiana.	K 0500	**K500**– It is the intent of the facility to ensure fuel-fired water heaters have current inspection certificates to ensure the water heaters are in safe operating condition to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 4/18/2023 a Certified Water Heater Inspector inspected the four fuel fired water heaters and provided the facility with Certificates of Inspection including 1) the service water heater identified as IN321485 2) service water heater identified as IN321956 3) service water heater identified as IN321957 4) service water heater identified as IN321958 to meet set standards. The Administrator verified the inspections and receipt of the documentation on 4/18/2023 . 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. 3. **MEASURES TO PREVENT REOCCURRENCE**:	04/19/2023

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	This finding was reviewed with the Executive Director, the Maintenance Director, and the Maintenance Assistant during the exit conference. 3.1-19(b)		a. On 4/18/2023 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that fuel-fired water heaters must be inspected and a Certificate of Inspection retained at the facility to meet set standards. b. Maintenance Supervisor/designee will check all fuel-fired water heaters annually to ensure they are inspected and documentation retained at the facility 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 Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system	

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			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 4/19/2023.**	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 wall mounted electrical outlet boxes in the Laundry Utilities Room was protected and was not broken. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. Article 406.5, states receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect 10 residents, staff, and visitors in the vicinity of the Laundry Utilities Room. Findings include: Based on observations with the Maintenance	K 0511	**K511 -** It is the intent of the facility to ensure wall mounted electrical outlet boxes in the laundry utilities room is protected and not broken to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 4/18/2023 the Maintenance Supervisor/designee installed a new electrical outlet and cover plate near the floor in the laundry utilizes room to meet set standards. The Administrator verified the work on 4/18/2023 . 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**:	04/19/2023

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	Director and the Maintenance Assistant during a tour of the facility from 9:05 a.m. to 11:20 a.m. on 04/03/23, the receptacles in the wall mounted outlet box near the floor in the Laundry Utilizes Room was broken in half which exposed the electrical wiring in the box. The outlet box was also not equipped with a cover plate. Based on interview at the time of observation, the Maintenance Director agreed the receptacles were broken and the outlet box was not provided with a cover plate. This finding was reviewed with the Executive Director, the Maintenance Director, and the Maintenance Assistant during the exit conference. 3.1-19(b)		a. All residents and all staff and visitors have the potential to be affected but none were. On 4/18/2023 the Maintenance Supervisor/designee inspected all electrical outlets throughout the facility to ensure outlets are not broken and covers are on and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 4/18/2023 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that electrical outlets are not broken and have properly installed covers to meet set standards. b. Maintenance Supervisor/designee will inspect all electrical outlets throughout the facility monthly to ensure they are not broken and covers are properly installed 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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	155389	A. BUILDING 01 B. WING	04/03/2023

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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 4/19/2023.**	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation, and interview; the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance within the most recent four-year period in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning	K 0521	**K521** – It is the intent of the facility to ensure all fire dampers in the facility are inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**:	04/19/2023

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	and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. The test and inspection frequency shall be every 4 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. Section 19.4.3 states full unobstructed access to the fire damper shall be verified and corrected as required. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Maintenance Director and the Maintenance Assistant from 11:20 a.m. to 1:10 p.m. on 04/03/23, documentation of fire damper inspections conducted within the most recent four-year period was not available for review. Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 9:05 a.m. to 11:20 a.m. on 04/03/23, a fire damper was installed in HVAC ductwork in the corridor wall outside the Equipment Room near the west nurse's station. The fire damper inspection contractor had affixed a sticker to the fire damper indicating the most recent inspection and necessary maintenance was performed on 09/20/16 which was more than four years old.		1.On 4/18/2023 a Certified Contractor/designee conducted an inspection of the smoke/fire dampers in the facility to meet set standards. The Administrator verified the inspection and documentation on 4/18/2023 . **1.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **2.MEASURES TO PREVENT REOCCURRENCE**: 1.On 4/18/2023 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that smoke/fire dampers must be properly inspected and maintained including inspections at least once every four years to meet set standards. 2.Maintenance Supervisor/designee will ensure the smoke/fire dampers are properly inspected and maintained including an inspection at least once every four years 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. 3.The Administrator will	

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	Based on interview at the time of record review and of the observations, the Maintenance Director stated fire damper inspection and maintenance documentation was not available for review and agreed documentation of fire damper inspections conducted within the most recent four-year period was not available for review. This finding was reviewed with the Executive Director, the Maintenance Director, and the Maintenance Assistant during the exit conference. 3.1-19(b)		monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **3.MONITORING CORRECTIVE ACTION**: 1.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 4/19/2023.**	
K 0930 SS=A Bldg. 01	NFPA 101 Gas Equipment - Liquid Oxygen Equipment Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) Based on observation and interview, the facility failed to protect 1 of 47 resident rooms from the use of liquid oxygen containers stored in a patient	K 0930	**K930**– It is the intent of the facility to ensure to protect resident rooms from the use of liquid	04/19/2023

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	bed location or patient care room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.7.4 states the maximum total quantity of liquid oxygen permitted in storage and in use in a patient bed location or patient care room shall be 120 L (31.6 gallons), provided that the patient bed location or patient care room, or both, are separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour in accordance with the adopted building code. Per Centers for Medicare & Medicaid Services (CMS), this practice is deficient according to NFPA 99, 2012 Edition, Section 11.7.4, but NFPA has released a Tentative Interim Amendment (TIA) for that section and CMS will be issuing further guidance on that code section. LSC Section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic closing. This deficient practice could affect over 1 resident, staff, and visitors in the vicinity of Room 7. Findings include: Based on observations with the Maintenance Assistant during a tour of the facility from 9:05 a.m. to 11:20 a.m. on 04/03/23, one liquid oxygen container was stored in resident sleeping Room 7. Room 7 was not separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour. The corridor door to the room was not self-closing or automatic closing and was not equipped with a minimum 45-minute fire resistance rating label affixed to the door. Based on interview at the time of the observations, the Maintenance Assistant agreed one liquid oxygen container was stored in Room 7 and the room was not maintained with a minimum fire resistance		oxygen containers stored in a patient bed location or patient care room to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 4/18/2023 the Director of Nursing/designee removed the one liquid oxygen container that was stored in resident sleeping room 7 to meet set standards. The Administrator verified the work on 4/18/2023. 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 4/18/2023 Director of Nursing/designee checked all areas of the facility for improperly stored oxygen containers and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 4/18/2023 the Administrator inserviced the Director of Nursing and all other nursing staff on the requirement that oxygen containers must be in the proper storage areas to meet set standards. b. Director of Nursing/designee will inspect all oxygen containers throughout the facility weekly to ensure they are properly stored as a part of the facility's oxygen handling Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed	

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	rating of 1 hour. This finding was reviewed with the Executive Director, the Maintenance Director, and the Maintenance Assistant during the exit conference. 3.1-19(b)		and resolved immediately. Director of Nursing/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Oxygen Policy schedule and validate the documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Director of Nursing 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 4/19/2023.**	