STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155430	A. BUILDING -- B. WING	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT ROCHESTER	340 E 18TH STREET ROCHESTER, IN 46975

(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: 07/01/24 Facility Number: 000326 Provider Number: 155430 AIM Number: 100290770 At this Emergency Preparedness survey, Hickory Creek at Rochester was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 36 and had a census of 29 at the time of this survey. The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by: Quality Review conducted on 07/02/24	E 0000		
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), §485.625(a)(1)-(2), §485.727(a)(1)-(2),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tommi Pruitt	Executive Director	08/06/2024

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

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	§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, and updated at least annually. The plan must			

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	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 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 record review with the Administrator on 07/01/24 between 9:42 a.m. and 11:44 a.m., the facility failed to provide a risk assessment. Based on interview at the time of record review, the Administrator provided multiple policies regarding	E 0006	REQUESTING DESK REVIEW E006 It is the policy of Hickory Creek Rochester to have a plan based on all hazards vulnerability risk assessment that address the resident population, including those at risk, as well as the type of services that the facility has to ability to provide during an emergency and the continuity of operations including delegations of authority and succession plans. 1 The Emergency Preparedness plan has been amended to include a Hazard Vulnerability Assessment for Hickory Creek Rochester. The	07/17/2024

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	potential hazards; however, she was not able to provide documentation of a risk assessment to determine the hazards. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.		plan includes natural events, human events other events. All residents, including those at risk will be addressed in the emergency preparedness plan as well as the type of services the facility is able to provide in an emergency. 2 All residents have the potential to be affected by the practice. 3 All staff will be in-serviced on the policy by the Maintenance Director or designee. 4 A plan based on all hazards vulnerability assessment will be reviewed monthly for 6 months and bi-annually thereafter by the Executive Director or designee to ensure all residents including those at risk are addressed as well as the type of services the facility could provide in an emergency, and continuity of operations including delegations of authority. The results of the monthly review will be reviewed in the monthly QAPI meeting to discuss the suitability of the plan and whether changes need to be made to it. Date of Compliance: July 17, 2024	
E 0007 SS=F Bldg. --	403.748(a)(3), 416.54(a)(3), 418.113(a)(3), 441.184(a)(3), 482.15(a)(3), 483.475(a)(3), 483.73(a)(3), 484.102(a)(3), 485.625(a)(3), 485.68(a)(3), 485.727(a)(3), 485.920(a)(3), 491.12(a)(3), 494.62(a)(3) EP Program Patient Population			

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	§403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(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:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] Based on record review and interview, the facility failed to ensure the emergency preparedness plan addressed resident population, including, but not limited to, persons at-risk; in accordance with 42	E 0007	REQUESTING DESK REVIEW E007	07/17/2024

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	CFR 483.73(a)(3). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator on 07/01/24 between 9:42 a.m. and 11:44 a.m., no documentation could be provided ensuring the emergency preparedness plan addressed resident population, including, but not limited to, persons at-risk. Based on interview at the time of record review, the Administrator discussed the resident population but was unable to provide any documentation addressing the patient population. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.		It is the policy of Hickory Creek Rochester to have emergency procedures that address the resident population, including those at risk, as well as the type of services that the LTC facility has to ability to provide during an emergency and the continuity of operations including delegations of authority and succession plans. The Emergency Preparedness plan has been amended to include the risk assessment in the emergency preparedness plan binder. Hickory Creek has a plan in place that includes our persons at risk and the type of services needed for the resident. The risk assessment policy and procedure have been updated and put in the binder as well. All residents, including those at risk will be addressed in the emergency preparedness plan as well as the type of services the facility has to the ability to provide in an emergency. All residents have the potential to be affected by the practice. The Emergency preparedness plan will be updated and will be reviewed on an annual basis by the Maintenance Director or designee to ensure all residents including those at risk are addressed as well as the type of services the facility could provide in an emergency, and continuity of operations including delegations of authority.	

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			All staff will be in- serviced on the policy by the Maintenance Director or designee. The results of any future reviews of the Emergency Preparedness Plan will be reviewed ongoing during the facility QAPI meeting process. Date of Compliance: July 17, 2024	
E 0025 SS=F Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b)(7), 482.15(b)(7), 483.475(b)(7), 483.73(b)(7), 485.625(b)(7), 485.920(b)(6), 494.62(b)(6) Arrangement with Other Facilities §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to			

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	maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other LTC facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility resident. This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator on 07/01/24 between 9:42 a.m. and 11:44 a.m., the facility provided a general two-page corporate transfer agreement between all of the corporation facilities. The agreement failed to take into account the patient population and the ability for the receiving facility to provide continuity of services. This facility is unable to accommodate and provide continuity of care to the varying	E 0025	REQUESTING DESK REVIEW E025 It is the policy of Hickory Creek Rochester to have an arrangement with Rochester Community Center to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility resident, and the continuity of operations including delegations of authority. 1 The Emergency Preparedness plan has been amended to include an arrangement with Hickory Rochester Community Center to receive residents in the event of limitations or cessation of	07/17/2024

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	degree of medical services needed by the Corporation residents i.e., residents using ventilators. Based on interview at the time of record review, the Administrator contacted the corporate office and confirmed this was their transfer agreement with other facilities. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.		operations to maintain the continuity of services. 2 All residents have the potential to be affected by the practice. An agreement has been signed with Rochester Community Center to receive residents in the event of limitations or cessation of operations to maintain the continuity of services. 3 All staff will be in-serviced on the policy by the Executive Director or designee. 4 An arrangement with Rochester Community Center to receive residents in the event of limitations or cessation of operations to maintain the continuity of services will be reviewed bi-annually thereafter by the Executive Director or designee to ensure all residents including those at risk are addressed as well as the type of services the facility could provide in an emergency, and continuity of operations including delegations of authority. The results of the biannual review will be reviewed in the QAPI meeting to discuss the suitability of the plan and whether changes need to be made to it. Date of Compliance: July 17, 2024	
K 0000 Bldg. 01				

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	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: 07/01/24 Facility Number: 000326 Provider Number: 155430 AIM Number: 100290770 At this Life Safety Code survey, Hickory Creek at Rochester was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined and verified to be of Type II (222) construction and 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 battery operated smoke detectors in all resident sleeping rooms. The building is partially protected by a propane fueled 60 kW emergency generator. The facility has a capacity of 36 and had a census of 29 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has three detached buildings providing facility services which were not sprinklered. One building was used as for activity storage, one for miscellaneous storage and the other was used for oxygen storage. Quality Review conducted on 07/02/24	K 0000		

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K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure the egress lighting for 1 of 3 exit means of egress was arranged so the failure of any single lighting fixture would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect staff and up to 15 residents. Findings include: Based on observations during tour of the facility with the Administrator on 07/01/24 between 12:35 p.m. and 1:35 p.m., the exit means of egress from the front entrance of the facility was not completely illuminated towards the public way. One egress light fixture was located on each side of the exterior of the front doors of the facility; however, only one was operational and illuminated at the time of observation during tour. Based on interview at the time of observation, the Administrator agreed that only one fixture was providing illumination of the exit discharge. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)	K 0281	REQUESTING DESK REVEIW K281 It is the policy of Hickory Creek Rochester to have illumination of means of egress at all exits. To ensure the safety of all residents entering and exiting the facility 1 Immediately following the Life Safety Survey Maintenance Director put in a new light at the front entrance. 2 All residents have the potential to be affected by the practice. The Maintenance Director completed the inspection of the facility to ensure no other exterior lights were needing replaced. 3 Maintenance Director will round each week to ensure exit means of egress are appropriately lit with operational and illuminated fixtures. 4 Director of Maintenance/designee will complete weekly audit of entire facility to ensure all light are working correctly. The Maintenance Director will review each weekly report with the	07/01/2024

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			administrator to ensure practices are effective. The results will be reviewed ongoing during the facility QAPI meeting process. Date of Compliance: July 1, 2024	
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). Based on observation and interview, the facility failed to ensure 1 of 1 Therapy Room, with wood paneling, had a flame spread rating of Class A or Class B in accordance with 19.3.3.1. LSC 101 10.2.3.4 states products required to be tested in accordance with ASTM E 84, Standard Test Method for Surface Burning Characteristics of Building Materials or ANSI/UL 723, Standard for Test for Surface Burning Characteristics of Building Materials shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall	K 0331	REQUESTING DESK REVIEW K331 It is the intent of the facility to ensure that any exposed wood without flame rated spray is sealed appropriately. 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Education provided to maintenance director related to interior wall and ceiling finishes. Exposed wood in the therapy room has been treated with fire rated spray. 2 How will you identify other	07/18/2024

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	not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect staff and up to 2 residents in the Therapy Room. Findings include: Based on observation and interview during a tour of the facility with the Administrator on 07/01/24 between 12:35 p.m. and 1:35 p.m., the Therapy Room contained wood paneling covering approximately 48 inches of the lower half of the walls. Based on interview at the time of the observations, the Administrator could not provide documentation to show the flame spread rating of the paneling. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director to ensure that any exposed wood without flame rated spray is sealed appropriately. 3 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Weekly audit of entire facility to ensure compliance. 4 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? Weekly facility walk through will be completed by the Maintenance Supervisor/designee weekly x4 weeks, monthly x2 months, and annually thereafter. The results will be reviewed ongoing during the facility QAPI meeting process. Date of Compliance: July 18, 2024	
K 0341 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously			

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	occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm system 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: Based on observation of the fire alarm control panel with the Administrator on 07/01/24 at 1:08 p.m., the displayed date and time on the fire alarm control panel was incorrect. The indicated date and time were 07/01/24 and 12:08 p.m. Based on interview at the time of observation, the Administrator agreed the fire alarm control panel had the wrong time displayed. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)	K 0341	REQUESTING DESK REVIEW K341 It is the intent of the facility to ensure that the fire alarm control panel will have the correct time. 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents have been affected. Education provided to maintenance director/designee related date and time on the fire alarm control panel. The fire control panel was corrected to display the appropriate time. 2 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director to ensure that the date and time is correct on the fire panel. 3 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not	07/02/2024

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			recur? Daily audit of the fire panel to ensure compliance. 4 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? Daily facility walk through will be completed by the Maintenance Supervisor/designee. The results will be reviewed ongoing during the facility QAPI meeting process. Date of Compliance: July 02, 2024	
K 0351 SS=E 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 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	K 0351	REQUESTING DESK REVIEW	07/02/2024

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	failed to ensure the spray pattern for sprinkler heads was not obstructed in 1 of 1 housekeeping closet in accordance with 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect staff and up to 15 residents. Findings include: Based on observations during a tour of the facility with the Administrator on 07/01/24 between 12:35 p.m. and 1:35 p.m., the top shelf in the housekeeping closet in the East Hall had cardboard boxes containing trash can liners stacked within 18 inches from the sprinkler deflector. The boxes would obstruct the flow of water if the sprinkler was activated. Based on interview at the time of observation, the Administrator and Housekeeper agreed the boxes were within 18 inches of the sprinkler deflector. The Housekeeper removed the boxes from obstructing the sprinkler deflector prior to exit. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		K351 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents have been affected by the alleged deficient practice. The cardboard boxes were removed from the East Hall closet 2 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All staff have been educated on not obstructing the spray pattern for sprinkler heads, nothing can be 18inches from the sprinkler head. 7/02/2024. All areas have been inspected by the Maintenance Director to ensure there are no obstructions for the sprinkler heads. 3 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Maintenance/designee will do weekly checks of all rooms/ storage areas to ensure compliance. 4 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? Weekly facility walk through will be completed by the Maintenance Supervisor/designee. The results will be reviewed ongoing during the	

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			facility QAPI meeting process. Date of Compliance: July 02, 2024	
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 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.			

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	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 1 laundry room corridor door on the West Hall had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect staff and up to 15 residents in the West Hall. Findings include: Based on observation with the Administrator on 07/01/24 at 1:05 p.m., the corridor door to the laundry room did not self-close into the frame when tested. When opened fully the door stuck to the floor preventing it from self-closing. Based on interview at the time of observation, the Administrator acknowledged the corridor door would not self-close into the door frame. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)	K 0363	REQUESTING DESK REVIEW K363 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents have been affected by the alleged deficient practice. Door to laundry room has been fixed to ensure the door closes properly by the Maintenance Director 2 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by alleged deficient practice. All self-closing doors were checked by Maintenance to ensure proper closure 3 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The maintenance/designee will do weekly checks of all self-closing doors ensuring compliance. 4 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program	07/18/2024

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			will be put into place? Weekly facility walk through will be completed by the Maintenance Supervisor/designee. The results will be reviewed ongoing during the facility QAPI meeting process. Date of Compliance: July 18, 2024	
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 ground fault circuit interrupter (GFCI) in bathroom 3 was properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could affect staff and up to 18 residents. Findings include: Based on observation and interview with the Administrator during a facility tour on 07/01/24 between 12:35 p.m. and 1:25 p.m., when the GFCI electric receptacle in Bathroom 3 was tested with a GFCI tester the GFCI receptacle failed to trip and did not break the electrical circuit. Based on interview at the time of observation, the Administrator agreed the GFCI electric receptacle did not properly work when tested and the tester	K 0511	REQUESTING DESK REVIEW K511 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents have been affected by the alleged deficient practice. A GFCI receptacle was replaced by Maintenance Director. 2 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by alleged deficient practice, Maintenance has changed the GFCI plug in bathroom 3, and it works properly. All other GFCI receptacles were checked to	07/18/2024

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	was indicating a "Bad Ground" wiring issue. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		ensure receptables are working properly. 3 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Maintenance/designee will do weekly checks of all GFCI plugs in the building. 4 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? 1 time per week for 4 weeks, monthly for 4 months then on going will be completed by the Maintenance Supervisor/designee. The results will be reviewed ongoing during the facility QAPI meeting process. Date of Compliance: July 18, 2024	
K 0906 SS=D Bldg. 01	NFPA 101 Gas and Vacuum Piped Systems - Central Supply Gas and Vacuum Piped Systems - Central Supply System Operations Adaptors or conversion fittings are prohibited. Cylinders are handled in accordance with 11.6.2. Only cylinders, reusable shipping containers, and their accessories are stored in rooms containing central supply systems or cylinders. No flammable materials are stored with cylinders. Cryogenic liquid storage units intended to supply the facility are not used to transfill. Cylinders are kept away from sources of heat. Valve protection caps are secured in place, if supplied, unless cylinder is in use. Cylinders are not stored in tightly closed spaces. Cylinders in use and			

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	storage are prevented from exceeding 130 degrees Fahrenheit, and nitrous oxide and carbon dioxide cylinders are prevented from reaching temperatures lower than manufacture recommendations or 20 degrees Fahrenheit. Full or empty cylinders, when not connected, are stored in locations complying with 5.1.3.3.2 through 5.1.3.3.3, and are not stored in enclosures containing motor-driven machinery, unless for instrument air reserve headers. 5.1.3.2, 5.1.3.3.17, 5.1.3.3.1.8, 5.1.3.3.4, 5.2.3.2, 5.2.3.3, 5.3.6.20.4, 5.6.20.5, 5.3.6.20.7, 5.3.6.20.8, 5.3.6.20.9 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 outdoor oxygen storage locations was provided with proper ventilation. NFPA 99, 11.3.1* Storage for nonflammable gases equal to or greater than 85 m3 (3000 ft3) at STP shall comply with 5.1.3.3.2 and 5.1.3.3.3. Section 5.1.3.3.3 Ventilation for Outdoor Locations states outdoor locations surrounded by impermeable walls shall have protected ventilation openings located at the base of each wall to allow free circulation of air within the enclosure. This deficient practice could affect only staff when transfilling. Findings include: Based on observation and interview with the Administrator during a facility tour on 07/01/24 between 12:35 p.m. and 1:25 p.m., the plastic storage shed located outside the rear of the building containing 8 bulk liquid oxygen storage containers did not have ventilation to allow free circulation of the air within the enclosure. Based on interview at the time of observation, the Administrator identified the shed as storage for the bulk liquid oxygen containers.	K 0906	REQUESTING DESK REVIEW K906 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents have been affected by the alleged deficient practice. A vent was installed by the Maintenance Director. 2 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No residents have the potential to be affected by alleged deficient practice. Maintenance has put in a vent to allow free circulation of the air within the enclosure. 3 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Maintenance Director will	07/25/2024

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	This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		ensure vent is clean and allows air flow. 4 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? On going walk through will be completed by the Maintenance Supervisor/designee of any new buildings. The results will be reviewed ongoing during the facility QAPI meeting process. Date of Compliance: July 18, 2024	