STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155771	A. BUILDING -- B. WING	09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE	1070 W JEFFERSON ST FRANKLIN, IN 46131

(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: 09/26/23 Facility Number: 001127 Provider Number: 155771 AIM Number: 200247220 At this Emergency Preparedness survey, Otterbein Franklin Senior Life Comm Res & Com Care was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 208 certified beds. At the time of the survey, the census was 150. Quality Review completed on 10/02/23	E 0000	K000 The creation and submission of this Plan of Correction do not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or any violation of the regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post-survey 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: 09/26/23 Facility Number: 001127 Provider Number: 155771 AIM Number: 200247220 At this Life Safety Code Survey, Otterbein	K 0000	K000 The creation and submission of this Plan of Correction do not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or any violation of the regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shannon Logan	Administrator	10/13/2023

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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	Franklin Senior Life Comm Res & Com Care 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. Otterbein Franklin Senior Life Comm Res & Com Care consists of four separate but connected buildings constructed at four different times: Building 01 an NCC facility built in 1957, is a three story sprinklered building of Type I (332) construction with a basement; Building 02 built in 1980 is a three story sprinklered building of Type I (332) construction with a basement; Building 03 built in 1992 is a one story sprinklered building of Type I (332) construction with a basement; and Building 04 built in 2000 is a three story sprinklered building of Type I (332) construction. Because all buildings are of the same type of construction, the facility was surveyed as one building. The facility has a fire alarm system with smoke detection in the corridors and all areas open to the corridor. In Building 02, 47 battery operated detectors were provided in resident rooms in Health Center 2 and Health Center 3. All other resident rooms in Building 02 are provided with hard wired smoke detectors. In Building 03 and Building 04, hard wired smoke detectors are installed in all resident rooms. The healthcare portion of the facility has a capacity of 208 and had a census of 150 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 10/02/23		of a post-survey review.	

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K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. Based on observation and interview, the facility failed to maintain protection of 1 of 4 interior stairwells. LSC 19.3.1 requires vertical openings shall be enclosed or protected in accordance with Section 8.6. LSC 8.6.1 requires every floor that separates stories in a building shall be constructed as a smoke barrier. LSC 8.6.5 states see 7.1.3.2.1 for enclosures of exits. LSC 7.1.3.2.1 states the separation shall have a minimum 1-hr fire resistance rating where the exit connects three stories or less. Fire doors assemblies are in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, Section 4.8.4.1 states the clearance under to bottom of of a door shall be a maximum of 3/4ths inch. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of Stair 17 in Building 02 on the second floor. Findings include: Based on observations with the Maintenance Manager and the Maintenance Technician during a tour of the facility from 12:40 p.m. to 3:40 p.m. on 09/26/23, a four inch square hole was noted in the	K 0311	K311 – Vertical Openings - Enclosure **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. The two holes noted in the stairwell were repaired on 10/11/2023 by removing the foam, fixing the hole with drywall and filling fire stop in the openings. (attachment #1, #2, #3, and #4)	10/13/2023

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	stairwell wall above the suspended ceiling above the stairwell door across from the Beauty Shop in Building 02 on the second floor. The stairwell door was affixed with a 90-minute fire resistance rating label and latched into the door frame. Based on interview at the time of the observations, the Maintenance Manager stated the stairwell is identified as Stair 17 and agreed the aforementioned hole in the stairwell wall did not maintain the fire resistance rating of the stairwell wall. These findings were reviewed with the Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b)		Audit completed on all emergency stairwells and vertical openings on 10/11/2023. (attachment #5 and #6) **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** An audit of the stairwells will be completed every two weeks for 3 months or until 100% compliance is met. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Any identified deficiencies will be corrected upon discovery and reviewed by the QAPI committee for further recommendation. **By what date the systemic changes for each deficiency will be completed?** 10/13/2023	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.			

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	9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Manager and the Maintenance Technician during a tour of the facility from 12:40 p.m. to 3:40 p.m. on 09/26/23, the remote fire alarm control panel at the Building 02 second floor nurse's station was in the trouble mode. The display for the remote fire alarm control panel read "Open circuit General NAC" as the cause of fire alarm system trouble. Based on interview at the time of the observations, the Maintenance Manager stated the main fire alarm control panel was replaced recently, the fire alarm system will activate if need be but the fire alarm system control panel keeps going back into the trouble mode following repeated contractor visits for repair. These findings were reviewed with the Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b)	K 0345	K345 – Fire Alarm System – Testing and Maintenance **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. The fire alarm control panel vendor, AADCO corrected the issue on 10/11/2023. (attachment #7 and #8) **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** A maintenance check of the fire panel is completed daily. An audit of the fire panel will be completed, by the Maintenance Manager and/or his designee, once a week until the end of phase one construction to ensure that the control panel does not reflect any trouble alarms. **How will the corrective action(s) be monitored to**	10/13/2023

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			ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Any identified deficiencies will be corrected upon discovery and reviewed by the QAPI committee for further recommendation. **By what date the systemic changes for each deficiency will be completed?** 10/13/2023	
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 ensure 1 of over 3 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and	K 0353	K353 – Sprinkler System – Maintenance and Testing **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	10/13/2023

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	Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations with the Maintenance Manager and the Maintenance Technician during a tour of the facility from 12:40 p.m. to 3:40 p.m. on 09/26/23, the facility has supervised wet sprinkler systems. The manufacture date of 2017 was listed on the face of the sprinkler system gauge located at the sprinkler system riser for Building 01 in the Building 04 Mechanical Room. No recalibration date information was affixed to the sprinkler system gauge. Based on interview at the time of the observations, the Maintenance Manager stated he did not believe the sprinkler system gauge had been recalibrated within the most recent five year period and agreed the sprinkler system gauge was more than five years old. These findings were reviewed with the Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 Murphy's Special Care wings in Building 03. 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		**practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. Audit completed on all riser gauges and all electrical rooms to look for any misplaced ceiling tiles on 10/11/2023. Please see before and after pictures (attachment #9) Koorsen Fire & Security replaced sprinkler gauge on system 9 in building 4 (attachment #10, #11, # and #13) **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** A routine audit has been added to WorxHub for a monthly check for any misplaced ceiling tiles. A check for riser gauge dates have been added to WorxHub annually. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Any identified deficiencies will be corrected upon discovery and	

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	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 sprinkler and the type of construction. This deficient practice could affect over 30 residents, staff, and visitors in the Murphy's Special Care wing in Building 03. Findings include: Based on observations with the Maintenance Manager and the Maintenance Technician during a tour of the facility from 12:40 p.m. to 3:40 p.m. on 09/26/23, a ten inch long triangular shaped section of suspended ceiling tile was missing in the Murphy's Special Care wing Electrical Room in Building 03. Based on interview at the time of the observations, the Maintenance Manager agreed the triangular shaped hole in the ceiling tile would delay activation of the sprinkler located in the Electrical Room. These findings were reviewed with the Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b)		reviewed by the QAPI committee for further recommendation. **By what date the systemic changes for each deficiency will be completed?** 10/13/2023	
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			

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	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. 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 over 20 corridor doors on the second floor in Building 02 had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the second floor Nurse's Office in Building 02.	K 0363	K363 – Corridor – Doors **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged	10/13/2023

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	Findings include: Based on observations with the Maintenance Manager and the Maintenance Technician during a tour of the facility from 12:40 p.m. to 3:40 p.m. on 09/26/23, the corridor door to the Nurse's Office on the second floor in Building 02 was propped in the fully open position with a wedge placed on the floor under the door. Based on interview at the time of the observations, the Maintenance Manager agreed the aforementioned corridor door had an impediment to closing and latching into the door frame and would not resist the passage of smoke and removed the wedge from under the door. These findings were reviewed with the Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b)		deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. The wedge that was propping the supervisor's door open was immediately removed by the Maintenance Manager on 9/26/2023 during the tour with the life safety surveyor. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** An audit will be completed by the unit manager and/or her designee daily for one week, three times a week for two weeks, and twice a week for one week to ensure that no doors are inappropriately propped open. (attachment #14) **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Any identified deficiencies will be corrected upon discovery and reviewed by the QAPI committee for further recommendation. **By what date the systemic changes for each deficiency**	

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			will be completed? 10/13/2023	
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 1 of 10 smoke barrier walls were protected to maintain the fire resistance rating of the smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect over 40 residents, staff and visitors on the second floor in Building 02. Findings include: Based on observations with the Maintenance Manager and the Maintenance Technician during a tour of the facility from 12:40 p.m. to 3:40 p.m. on 09/26/23, foam was being used to firestop four holes which were noted in the smoke barrier wall above the corridor door set at the entrance to Building 02 from Building 04 on the second floor. Each door in the corridor door set was affixed with	K 0372	K372 – Subdivision of Building Spaces – Smoke Barrier **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. The hole in the stairwell will be	10/13/2023

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	a 90-minute fire resistance rating label and latched into the door frame. Based on interview at the time of the observations, the Maintenance Manager stated he was not aware of the fire resistance rating of the foam used to firestop the holes in the smoke barrier wall. These findings were reviewed with the Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b)		fixed by cutting out foam and replacing it with proper fire stop material on 10/11/2023. (attachment #15 and #16) **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** An audit of the stairwells will be completed every two weeks for three months or until 100% compliance is met. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Audits will be reviewed by the QA committee. Once initial audits have been completed, and 100% compliance has been met, the committee may decide to discontinue audits. **By what date the systemic changes for each deficiency will be completed?** 10/13/2023	
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	K 0521	K521 – HVAC **What corrective action(s) will**	10/20/2023

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	155771	A. BUILDING 01 B. WING	09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE	1070 W JEFFERSON ST FRANKLIN, IN 46131

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	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 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 review of the fire alarm system inspection contractor's "Inspection and Testing Form" documentation dated 07/20/23 with the Maintenance Manager and the Building Services Coordinator during record review from 9:10 a.m. to 12:15 p.m. on 09/26/23, fire damper inspection and maintenance documentation was not available for review. Based on interview at the time of record review, the Building Services Coordinator stated		**be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. SafeCare is scheduled to inspect identified fire dampers on 10/16/2023. A WorxHub ticket has been created so that fire dampers are inspected annually. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Audits of the fire dampers will be conducted by the Maintenance Manager and/or his designee weekly for four weeks and then monthly for three months. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Audit will be reviewed by the QA	

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	the fire alarm inspection contractor performs fire damper inspections for the facility but agreed fire damper inspection and maintenance documentation was not included on fire alarm system inspection report. Based on observations with the Maintenance Manager and the Maintenance Technician during a tour of the facility from 12:40 p.m. to 3:40 p.m. on 09/26/23, a fire damper was installed in the wall mounted HVAC ductwork in the bathroom for resident sleeping Room 381 and Room 386 on the third floor in Building 02. A sticker with the manufacture date of 2008 was affixed to the fire damper in Room 381. The fire damper in Room 386 had an affixed sticker with the manufacture date of 2007. Neither fire damper had any affixed documentation indicating the date of the most recent inspection and necessary maintenance. These findings were reviewed with the Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b)		committee. Once initial audit is completed and 100% compliance is met, the committee may choose to discontinue the audit. **By what date the systemic changes for each deficiency will be completed?** 10/20/2023	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7			

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	Based on record review and interview, the facility failed to provide documentation of a fire drill conducted on the second shift for 1 of 4 quarters. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Overall Review of Quarterly Fire Drill" documentation and "Record of Alarm and Drill Report: Fire" documentation with the Maintenance Manager and the Building Services Coordinator during record review from 9:10 a.m. to 12:15 p.m. on 09/26/23, documentation of a fire drill conducted on the second shift in the second quarter (April, May, June) 2023 was not available for review. Based on interview at the time of record review, the Maintenance Manager stated the facility operates three shifts per day, one of the two fire drills conducted on 05/08/23 and on 06/16/23 was intended to be a second shift fire drill but was documented as a third shift fire drill and agreed documentation of a fire drill conducted on the second shift in the second quarter 2023 was not available for review. These findings were reviewed with the Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b) and 3.1-51(c)	K 0712	K712 – Fire Drills **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. Fire Drills were scheduled in WorxHub by the previous Maintenance Director. After auditing the dates and times of all fire drills over the last year, it was discovered that the fire drill that should have occurred during the second quarter on second shift was actually completed 15 mintues after second shift ended, which then made the drill effective for third shift. The Maintenance Manager has reconfigured the dates and times of each fire drill to occur early in the shifts to ensure that a timing mishap does not reoccur. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**	10/13/2023

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			The Maintenance Manager has reconfigured the dates and times of each fire drill to occur early in the shifts to ensure that a timing mishap does not reoccur. (attachment #17) **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Any identified deficiencies will be corrected upon discovery and reviewed by the QAPI committee for further recommendation. **By what date the systemic changes for each deficiency will be completed?** 10/13/2023	
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of			

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	fire development or spread is not present. 19.7.5.6 Based on observation and interview, the facility failed to ensure 1 of 2 smoke compartments on the second floor in Building 02 was maintained in accordance with 19.7.5.6. 19.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 19.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the	K 0753	K753 – Combustible Decorations **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. All coloring pages have been removed from the door on 9/26/2023. (attachment #18) **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All staff on HC2 were inserviced by the Unit Manager and/or his designee on 10/10/2023 to inform staff of the Combustible Decoration rule. (attachment #19) An Audit will be completed by the HC2 Unit Manager and/or his designee once weekly for four weeks to ensure there are no further coloring pages hanging on the doorways. (attachment #20) **How will the corrective**	10/13/2023

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	wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. (5)*They are decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Building 02 Server Room on the second floor. Findings include: Based on observations with the Maintenance Manager and the Maintenance Technician during a tour of the facility from 12:40 p.m. to 3:40 p.m. on 09/26/23, nearly the entire face of the corridor door to the second floor Server Room in Building 02 was covered with individual 8 inch by 10 inch sheets of paper art affixed to the corridor side of the door. Each sheet of paper did not have affixed documentation indicating the material was fire retardant or fire retardant treated. Based on interview at the time of the observations, the Maintenance Technician stated he was not aware if the affixed paper art had been treated with fire retardant material and agreed fire resistance rating documentation for the paper art was not available for review. These findings were reviewed with the Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b)		**action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Any identified deficiencies will be corrected upon discovery and reviewed by the QAPI committee for further recommendation. **By what date the systemic changes for each deficiency will be completed?** 10/13/2023	

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K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility failed to ensure unattended trash receptacles in 1 of 1 Building 02 Server Rooms were stored in a room protected as a hazardous area in accordance with Section 19.7.5.7. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Building 02 Server Room on the second floor. Findings include: Based on observations with the Maintenance Manager and the Maintenance Technician during a tour of the facility from 12:40 p.m. to 3:40 p.m. on 09/26/23, one unattended partially filled trash cart and one unattended partially filled trash can were stored next to one another in the Building 02 second floor Server Room by the dining room.	K 0754	K754 – Soiled Linen and Trash Containers **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient	10/13/2023

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	The trash cart had signage on the cart indicating it was 32 gallon capacity and the trash can was 20 gallon capacity. The combined capacity of the trash cart and the trash can exceeded 32 gallons. The Building 02 Server Room was open to the dining room which was open to the corridor. Based on interview at the time of the observations, the Maintenance Technician agreed the aforementioned trash receptacles were not being stored in a room protected as a hazardous area when unattended. These findings were reviewed with the Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b)		practice. The trash cans were immediately moved to an appropriate storage area on 9/26/2023. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Audits to ensure trash cans are appropriately covered and in an appropriate storage area will be completed by the back of the house supervisor and/or her designee daily for one week, three times a week for one week, and then twice weekly for two weeks. (attachment #21) **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Any identified deficiencies will be corrected upon discovery and reviewed by the QAPI committee for further recommendation. **By what date the systemic changes for each deficiency will be completed?** 10/13/2023	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable			

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	patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location	K 0920	K920 – Electrical Equipment – Power Cords and Extension Cords **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice.	10/13/2023

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	intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect one resident in Room 285 in Building 02 on the second floor. Findings include: Based on observations with the Maintenance Manager and the Maintenance Technician during a tour of the facility from 12:40 p.m. to 3:40 p.m. on 09/26/23, a computer tablet was plugged into a power strip which was laying on the resident bed in Room 285 in Building 02 on the second floor. The UL listing of the power strip could not be determined. Based on interview at the time of the observations, the Maintenance Manager agreed a power strip with an unknown UL listing was being used in the patient care vicinity at the aforementioned location. These findings were reviewed with the Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b)		An in-service was given to HC2 staff regarding the use of power strips on 10/10/2023 by the Unit Manager and/or her designee. (attachment #22) Social Services contacted family on 10/13/2023 to request a longer charging cord for resident's tablet. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** An audit will be conducted by the Maintenance Manager or his designee weekly for four weeks and then random audits once a month for three months for extension cord use. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Any identified deficiencies will be corrected upon discovery and reviewed by the QAPI committee for further recommendation. **By what date the systemic changes for each deficiency will be completed?** 10/13/2023	
K 0923 SS=D Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage			

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OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE	1070 W JEFFERSON ST FRANKLIN, IN 46131

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	Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility	K 0923	K923 – Gas Equipment – Cylinder	10/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155771	A. BUILDING 01 B. WING	09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	failed to ensure 1 of 10 cylinders of nonflammable gases such as oxygen in the Building 03 Rehabilitation wing area were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.3 states storage for nonflammable gases with a total volume equal to or less than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1 and 11.3.3.2. NFPA 99, Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of Building 03 Rehabilitation wing oxygen storage room. Findings include: Based on observations with the Maintenance Manager and the Maintenance Technician during a tour of the facility from 12:40 p.m. to 3:40 p.m. on 09/26/23, one of ten 'E' type oxygen cylinders was freestanding on the floor of the Building 03 Rehabilitation wing oxygen storage room and was not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of the observations, the Maintenance Manager agreed the oxygen cylinder was not properly chained or supported in a proper cylinder stand or cart. These findings were reviewed with the Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b)		and Container Storage **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have been identified as having the potential to be affected by the alleged deficient practice. The “E” type oxygen cylinder was immediately put in the secured area by the Maintenance Manager on 9/26/2023 during the tour with the Life Safety inspector. The Rehab staff was inserviced on the proper storing of Oxygen containers between 10/11/2023 – 10/13/2023 by the Unit Manager. (attachment #23) **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** An audit will be conducted by the Maintenance Manager and/or his designee to ensure oxygen containers are stored appropriately, daily for one week, three times a week for one week, and then twice weekly for two	

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			weeks. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Any identified deficiencies will be corrected upon discovery and reviewed by the QAPI committee for further recommendation. **By what date the systemic changes for each deficiency will be completed?** 10/13/2023	