STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING -- B. WING	07/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF WEST ALLEN	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(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: 07/31/23 Facility Number: 000215 Provider Number: 155322 AIM Number: 100267600 At this Emergency Preparedness survey, Majestic Care of West Allen was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 96 and had a census of 80 at the time of this survey. Quality Review completed on 08/03/23	E 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Desk Review.	
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility]			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Zach Krumwied	Executive Director	08/17/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING -- B. WING	07/31/2023

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	must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (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 all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [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. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to review and update all copies of the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a).	E 0004	ul class="BulletListStyle1 SCXW264838150 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text;	08/23/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 07/31/23 at 10:30 a.m., the EPP maintenance copy was not updated due to all required fields for the facility to fill out was left blank and was not reviewed within the past 12 months. Based on records review with the Administrator at 1:45 p.m., the Administrator provided an updated EPP with a review date of May 2023. Based on interview at the time of record review, the Administrator and Maintenance Director stated not all available copies of the EPP were updated and reviewed annually. The finding was reviewed with the Administrator and Maintenance Director during the exit conference.		-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; p paraid="1100367167" paraeid="{f0d54af7-5bd9-4f2d-ab44-ac026f38b89e}{234}" > - All copies of the EEP were reviewed and updated. 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; - All Residents have the potential to be affected by the deficient practice. All copies of the EEP will be reviewed and updated annually. p paraid="457812822" paraeid="{ca7eec4c-7cc4-485e-90a5-7c8612404bf9}{32}" >	

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			what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; - The Maintenance Director and IDT were on the process of reviewing and updating the EEP annually. ul class="BulletListStyle1 SCXW264838150 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and - The “EEP” QAPI audit tool will be completed by the ED or Designee to ensure that the EEP is reviewed and updated annually. The “EEP” QAPI audit tool will be completed monthly for one month, and quarterly for 3 months. If 100% compliance is not obtained an action plan will be developed. This information will be presented	

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			monthly to the QAPI committee.	
E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [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. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility 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 annually. *Additional Requirements for PACE and			

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	ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization 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 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility 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. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.			
	Based on record review and interview, the facility failed to review and update all copies of the emergency preparedness plan (EPP) Policies and Procedures at least annually in accordance with 42	E 0013	·p paraid="196435408" paraeid="{20f012fb-d002-4918-a567-59f6ae71b00c}{187}" >what corrective action(s) will be	08/23/2023

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	CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 07/31/23 at 10:30 a.m., the EPP Policies and Procedures maintenance copy was not updated due to all required fields for the facility to fill out was left blank and was not reviewed within the past 12 months. Based on records review with the Administrator at 1:45 p.m., the Administrator provided an updated EPP Policies and Procedures with a review date of May 2023. Based on interview at the time of record review, the Administrator and Maintenance Director stated not all available copies of the EPP Policies and Procedures were updated and reviewed annually. The finding was reviewed with the Administrator and Maintenance Director during the exit conference.		accomplished for those residents found to have been affected by the deficient practice; - All copies of the EEP were reviewed and updated. 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; - All Residents have the potential to be affected by the deficient practice. All copies of the EEP will be reviewed and updated annually. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; - The Maintenance Director and IDT were on the process of reviewing and updating the EEP annually.	

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			how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and - The “EEP” QAPI audit tool will be completed by the ED or Designee to ensure that the EEP is reviewed and updated annually. The “EEP” QAPI audit tool will be completed monthly for one month, and quarterly for 3 months. If 100% compliance is not obtained an action plan will be developed. This information will be presented monthly to the QAPI committee.	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and			

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	local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to review and update all copies of the emergency preparedness plan (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 07/31/23 at 10:30 a.m., the EPP Communication Plan maintenance copy was not updated due to all required fields for the facility to fill out was left blank and was not reviewed within the past 12 months. Based on records review with the Administrator at 1:45 p.m., the Administrator provided an updated EPP Communication Plan with a review date of May 2023. Based on interview at the time of record review, the Administrator and Maintenance Director stated not all available copies of the EPP Communication Plan were updated and reviewed annually. The finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0029	·p paraid="1870092811" paraeid="{55be43a0-03e0-4af3-9775-5db2a497e408}{142}" >what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - All copies of the EEP were reviewed and updated including the EEP communication plan. 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; - All Residents have the potential to be affected by the deficient practice. All copies of the EEP will be reviewed and updated annually. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	08/23/2023

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			- The Maintenance Director and IDT were on the process of reviewing and updating the EEP annually. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and - The “EEP” QAPI audit tool will be completed by the ED or Designee to ensure that the EEP is reviewed and updated annually. The “EEP” QAPI audit tool will be completed monthly for one month, and quarterly for 3 months. If 100% compliance is not obtained an action plan will be developed. This information will be presented monthly to the QAPI committee.	
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing			

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	§403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and			

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	testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.			
	Based on record review and interview, the facility failed to review and update all copies of the emergency preparedness plan (EPP) Training Program at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 07/31/23 at 10:30 a.m., the EPP Training Program maintenance copy was not updated due to all required fields for the facility to	E 0036	·p paraid="1985038775" paraeid="{1fc6d9ba-d92c-4752-a41e-30632d1d98a1}{231}" >what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - All copies of the EEP were reviewed and updated including	08/23/2023

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	fill out was left blank and was not reviewed within the past 12 months. Based on records review with the Administrator at 1:45 p.m., the Administrator provided an updated EPP Training Program with a review date of May 2023. Based on interview at the time of record review, the Administrator and Maintenance Director stated not all available copies of the EPP Training Program were updated and reviewed annually. The finding was reviewed with the Administrator and Maintenance Director during the exit conference.		the EEP training program. 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; - All Residents have the potential to be affected by the deficient practice. All copies of the EEP will be reviewed and updated annually. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; - The Maintenance Director and IDT were on the process of reviewing and updating the EEP annually. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and	

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(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
			- The “EEP” QAPI audit tool will be completed by the ED or Designee to ensure that the EEP is reviewed and updated annually. The “EEP” QAPI audit tool will be completed monthly for one month, and quarterly for 3 months. If 100% compliance is not obtained an action plan will be developed. This information will be presented monthly to the QAPI committee.	
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: 07/31/23 Facility Number: 000215 Provider Number: 155322 AIM Number: 100267600 At this Life Safety Code survey, Majestic Care of West Allen 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.	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Desk Review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 01 B. WING	07/31/2023

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	This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridor and hard wired smoke detectors in resident rooms 310-317. The remaining resident rooms have battery operated smoke detectors. The facility has a capacity of 96 and had a census of 80 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered which the exception of a detached garage used to store maintenance supplies and equipment. Quality Review completed on 08/03/23			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 4 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect staff and 20 resident that would use the service hall as an exit during an emergency. Findings include:	K 0211	ul class="BulletListStyle1 SCXW191942288 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" what corrective action(s) will be accomplished for those residents	08/23/2023

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	Based on an observation with the Maintenance Director on 07/31/23 at 12:31 p.m., the service hall exit corridor contained a lost and found cart that was stored in the hall. Based on interview at the time of observation, the Maintenance stated the lost and found cart was kept in the service hall. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		found to have been affected by the deficient practice; The lost and found cart on the service hall was moved to ensure that the means of egress was free of all obstructions or impediments. 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; p paraid="1108637328" paraeid="{ca7eec4c-7cc4-485e-90a5-7c8612404bf9}{230}" > -All Residents that reside on or near the service hall have the potential to be affected by this deficient practice. All 4 means of egress were ensured to be free of all obstructions or what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	

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			ul class="BulletListStyle1 SCXW191942288 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" All staff were educated on the requirement of ensuring that all means of egress must remain free of obstructions and impediments. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The “Means of Egress” QAPI audit tool will be completed by the ED or Designee to ensure that all egresses remain free of obstruction and impediment. The “Means of Egress” QAPI audit tool will be completed weekly for one month, and monthly for 3 months. If 100% compliance is not obtained an action plan will be developed. This information will be presented monthly to the QAPI committee.	

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K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.			

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	18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 2 of 5 exit doors and 1 of 1 exit gates were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 55 residents.	K 0222	ul="" role="list" what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All exit doors and exit gates had the keypad exit code posted in sight by the keypad. p="" paraid="51601886" paraeid="{99de7438-0a2e-4325-8657-3425838163f0}{134}"> how other residents having the	08/23/2023

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	Findings include: Based on observation with the Maintenance Director on 07/31/23 between 11:30 a.m. and 1:00 p.m., the 100-hall exit door, 200-hall exit door, and the exit gate outside of 300-hall are facility exits, were magnetically locked, and could be opened by entering a four-digit code on the access control pad. The code to open the two exit doors were not posted in sight by keypad, and the exit gate did not have a code posted. Based on interview at the time of observation, the Maintenance Director agreed the codes to open the exit doors and exit gate were not posted by the access control pads. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - All residents have the potential to be affected by this deficient practice. All exit doors and exit gates will have the keypad code posted in sight by the keypad. ul="" role="list" 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 will be educated on the requirement to have the keypad code placed in sight by the keypad. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and p="" paraid="425460149" paraeid="{99de7438-0a2e-4325-8657-3425838163f0}{220}"> The “Means of Egress” QAPI audit tool will be completed by the ED or Designee to ensure that all residents receive activities daily. The “Means of Egress” QAPI audit tool will be completed weekly for one month, and monthly for 3 months. If 100% compliance is not obtained an action plan will be developed. This information will be presented monthly to the QAPI committee.	

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K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 #1.) Based on observation and interview, the facility failed to ensure 3 of 3 battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect 6 staff and residents using the shower rooms. Findings include: Based on observation with the Maintenance Director on 07/31/23 between 11:30 a.m. and 1:00 p.m., the battery-operated emergency lights inside the three shower rooms did not work when tested. Based on interview at the time of the observations, the Maintenance Director agreed the battery-operated emergency lights failed to function when the respective test buttons were pushed. #2.) Based on records review, observation, and interview, the facility failed to ensure 3 of 3 battery backup lights were properly tested.	K 0291	ul class="BulletListStyle1 SCXW9099030 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The emergency lights in all 3 shower rooms were repaired or replaced to ensure proper function. 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; p paraid="162191364" paraeid="{bfb93b66-c6b4-4041-b912-35cd0d3e5d75}{67}" >	08/23/2023

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	Section 7.9.3.1.1 requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds. Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect 6 staff and residents using the shower rooms. Findings include: Based on observation with the Maintenance Director on 07/31/23 between 11:30 a.m. and 1:00 p.m., there were three battery-operated emergency light inside the three shower rooms. Based on records review at 1:40 p.m., testing documentation for the battery powered emergency lights were not available for review. Based on an interview at the time of record review and observation, the Maintenance Director confirmed there were battery powered lights in the shower rooms and stated the lights were not tested in the last year. The findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		All residents have the potential to be affected by this deficient practice. The maintenance director was educated on the requirement to test all emergency shower room lights for no less 30 seconds monthly and for annually. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; ul class="BulletListStyle1 SCXW9099030 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" All emergency shower room lights will be no less 30 seconds monthly and annually. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The “Emergency Shower Lighting”	

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			QAPI audit tool will be completed by the Maintenance Director or Designee to ensure that all such lights are functional and tested per requirement. The “Emergency Shower Lighting” QAPI audit tool will be completed weekly for one month, and monthly for 3 months. If 100% compliance is not obtained an action plan will be developed. This information will be presented monthly to the QAPI committee.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) #1.) Based on observation and interview, the facility failed to ensure 1 of 1 exit paths did not have conflicting exit signs. This deficient practice could affect 30 residents that need to use service hall exit from the dining room. Findings include: Based on observation with the Maintenance Director on 07/31/23 at 12:35 p.m., there were a set of closed smoke doors in the dinning/service corridor that had an "EXIT" sign above the door	K 0293	·p paraid="1938816043" paraeid="{6455936e-c34c-4640-98cb-4d1a64d49ccd}{81}" >what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The smoke doors located on the	08/23/2023

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	and a sign stating "do not enter staff only" posted on the door. This condition can cause confusion during an emergency evacuation. Based on an interview at the time of observation, the Maintenance Director agreed there were two conflicting sings and removed the "do not enter" sign. #2.) Based on record review and interview; the facility failed to install exit signage in 1 of 4 paths of egress in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect 20 residents on the 300-hall. Findings include: Based on observation with the Maintenance Director on 07/31/23 at 1:00 p.m., outside of the 300 hall the path of egress led to a locked solid gate and could not see were the path of egress led. There was no directional or exit signs to show the direction of the path of egress. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and confirmed that the path of egress was not obvious. The findings were reviewed with the Administrator and Maintenance Director during the exit conference.		dining/service area hall had the conflicting signs removed leaving on the EXIT sign above the door. Directional signs were placed at the end of the 300 to ensure that the path of egress was direction was identifiable. 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; All residents have the potential to be affected by this deficient practice. All staff were educated on the requirement to have EXITs clearly marked without conflicting signs. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All Exits and Egresses will have the appropriate signage and directional information.	

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	3.1-19(b)		how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The “Means of Egress” QAPI audit tool will be completed by the Maintenance Director or Designee to ensure that all such lights are functional and tested per requirement. The “Means of Egress” QAPI audit tool will be completed weekly for one month, and monthly for 3 months. If 100% compliance is not obtained an action plan will be developed. This information will be presented monthly to the QAPI committee.	
K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to maintain latching hardware on 1 of 4 smoke barrier doors to the 200-hall. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient	K 0300	·p paraid="333726448" paraeid="{64b3b098-adbf-409b-92a4-fa9bc9f279c0}{230}" >what corrective action(s) will be accomplished for those residents found to have been affected by the	08/23/2023

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	practice could affect 33 residents in two smoke compartments. Findings include: Based on observation with the Maintenance Director on 07/31/23 at 11:37 a.m., the set of smoke barrier doors to the 200-hall was provided with latching hardware but failed to latch when tested. Based on interview at the time of observation, the Maintenance Director agreed the smoke doors were equipped with latching devices, but the doors did not properly latch when tested. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		deficient practice; The set of smoke barrier doors to the 200 were repaired and adjusted to ensure that latching hardware was functional. 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; All residents have the potential to be affected by this deficient practice. All smoke barrier doors were tested to ensure that they latched correctly. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All smoke barrier doors will be kept in good repair and functional order to ensure they latch when tested or in use.	

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(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
			how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The “Smoke Barrier/Hazardous Area Doors” QAPI audit tool will be completed by the Maintenance Director or Designee to ensure that all such doors are functional and tested per requirement. The “Smoke Barrier/Hazardous Area Doors” QAPI audit tool will be completed weekly for one month, and monthly for 3 months. If 100% compliance is not obtained an action plan will be developed. This information will be presented monthly to the QAPI committee.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or			

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	155322	A. BUILDING 01 B. WING	07/31/2023

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	automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor doors to 2 of 5 hazardous areas containing fuel fired equipment was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient 40 residents in two smoke compartments. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 07/31/23 at 11:42 a.m. and at 1:05 p.m., the furnace room in the dining room and the mechanical room on the 200-hall which contain fuel fired equipment were equipped with self-closing devices, but the doors did not latch into the frame when tested. Based on interview at the time of observation, the	K 0321	·p paraid="529738787" paraeid="{8e4ef46b-9049-4080-b572-73294b632977}{9}" >what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The doors to the mechanical room on 200 and the dining room were repaired to ensure they latched. how other residents having the	08/23/2023

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	Maintenance Director agreed the rooms were hazardous areas containing fuel fired equipment and the doors did not automatically latch into the frame when tested. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this deficient practice. The maintenance director was educated on the requirement that all self-closing doors to hazardous areas must latch when tested. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All doors with hazardous materials were inspected to ensure that a self-closing door was in place and that the door latched to the frame when tested. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and	

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			The “Smoke Barrier/Hazardous Area Doors” QAPI audit tool will be completed by the Maintenance Director or Designee to ensure that all such doors are functional and tested per requirement. The “Smoke Barrier/Hazardous Area Doors” QAPI audit tool will be completed weekly for one month, and monthly for 3 months. If 100% compliance is not obtained an action plan will be developed. This information will be presented monthly to the QAPI committee.	
K 0345 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to ensure 1 of 3 manual fire alarm boxes (pull stations) in the 100-hall were not obstructed. LSC 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72 2010 edition 17.14.5 states manual fire alarm boxes shall be installed so that they are conspicuous,	K 0345	p="" paraid="638226920" paraeid="{53985717-42aa-4c2a-9cbd-cd89aacaeee3}{56}">what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The lift blocking the manual fire alarm box was moved to ensure that the alarm was unobstructed	08/23/2023

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	unobstructed, and accessible. This deficient practice could affect 25 residents in the 100 hall. Findings include: Based on observation with the Maintenance Director on 07/31/23 at 12:01 p.m., the pull station by the 100-hall exit had a Hoyer lift parked in front of the pull station. Based on interview at the times of observation, the Maintenance Director agreed the lift was blocking the pull station and removed the lift. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		and accessible. 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; All residents have the potential to be affected by this deficient practice. All staff were educated on the requirement that all manual fire alarm boxes be unobstructed and accessible. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All manual pull alarms will be installed and maintained in a that keeps them unobstructed and accessible. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The “Fire Detection and Alarm system” QAPI audit tool will be completed by the Maintenance Director or Designee to ensure that all system requirements are met and maintained. The “Fire Detection and Alarm system” QAPI audit tool will be completed weekly for one month, and monthly for 3 months. If 100% compliance is not obtained an action plan will be developed. This information will be presented monthly to the QAPI committee.	

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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 failed to ensure 2 of 6 sprinklers in the 200-hall lounge/dining room were installed in accordance with NFPA 13, 2010 Edition. Section 8.6.3.4.1 states unless the requirements of 8.6.3.4.2, 8.6.3.4.3, or 8.6.3.4.4 are met, sprinklers shall be spaced not less than 6 ft (1.8 m) on center. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 07/31/23 at 11:20 a.m., in the 200-hall lounge/dining room there were two sprinklers 5 feet apart. Based on interview at the time of the	K 0351	p="" paraid="1961862901" paraeid="{ff173100-46af-438c-8f9f-5b66fd610a12}{124}">what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The Sprinkler heads in the hall 200 lounge/dining hall were repaired to ensure that they were a minimum of 6 feet apart. 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; All	08/23/2023

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	observations, the Maintenance Director agreed the sprinklers were less than six feet apart and provide the measurement of five feet. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		residents have the potential to be affected by this deficient practice. An audit was performed to ensure that all sprinkler heads were a minimum of 6 feet apart. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All sprinkler heads will be a minimum of 6 feet apart. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The “Sprinkler /Fire Suppression System” QAPI audit tool will be completed by the Maintenance Director or Designee to ensure that all sprinkler heads are a minimum of apart. The “Sprinkler/Fire Suppression System” QAPI audit tool will be completed weekly for one month, and monthly for 3 months. If 100% compliance is not obtained an action plan will be developed. This information will be presented monthly to the QAPI committee.	
K 0353 SS=E 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			

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	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 4 of 8 sprinklers in the kitchen were not loaded and free of corrosion. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff and up to 20 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 07/31/23 at 12:18 p.m., in the kitchen two sprinkler heads by the dish washer were green and showed signs of corrosion. Also, two sprinkler heads by the cooktop were loaded with dirt and grease. Based on interview at the time of observation, the Maintenance Director agreed two sprinkler showed signs of corrosion and two sprinklers were loaded in the kitchen.	K 0353	p="" paraid="87169247" paraeid="{679fcdae-59e2-4203-a842-1c8d16f51fc2}{72}">what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The 4 Sprinkler heads noted in the kitchen as not being free or corrosion and not loaded were cleaned or replaced by the sprinkler system service provider. The sprinkler noted as being obstructed by a decoration has the obstruction removed. 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; All residents have the potential to be affected by this deficient practice. An audit was performed to ensure that all sprinkler heads were free corrosion, unloaded, free of foreign materials, and in functional order. what measures will be put into place and what systemic changes will be made to ensure that the	08/23/2023

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	#2.) Based on observation and interview, the facility failed to ensure 1 of 8 sprinkler heads in the 100-hall corridor were not obstructed in accordance with 19.3.5. 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. This deficient practice could up to 25 residents in the 100-hall. Findings include: Based on observation with the Maintenance Director on 07/31/23 at 11:5 a.m., the middle sprinkler head in the 100-hall was obstructed by a decoration hang from the sprinkler head. Based on interview at the time of observation, the Maintenance Director removed the decoration. The findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		deficient practice does not recur; All sprinkler heads will be not loaded and free of corrosion. All sprinklers will not show signs of leakage; be free of corrosion, foreign materials, paint, and physical damage. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The “Sprinkler /Fire Suppression System” QAPI audit tool will be completed by the Maintenance Director or Designee to ensure that all sprinklers will not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage. The “Sprinkler/Fire Suppression System” QAPI audit tool will be completed weekly for one month, and monthly for 3 months. If 100% compliance is not obtained an action plan will be developed. This information will be presented monthly to the QAPI committee.	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility	K 0361	·p paraid="866645037"	08/23/2023

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	failed to ensure 2 of 2 lounges open to the corridor were provide with electrically supervised automatic smoke detection system. LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect staff and up to 25 residents on the 200-hall. Findings include: Based on observations with the Maintenance Director on 07/31/23 at 11:39 a.m., the two lounges at the end of the 200-hall were open to the corridor and were not provided with electrically supervised automatic smoke detection. Based on interview at the time of observation, the Maintenance Director agreed the two lounges were open to the corridor and were not provided with electrically supervised automatic smoke detection. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		paraeid="{e9a2a411-02ee-4d33-9cef-18559d7c0972}{240}" >what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The two lounges at the end of the 200 were provided with electrically supervised automatic smoke detection. 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; All residents have the potential to be affected by this deficient practice. An audit was performed to ensure that all areas requiring electrically supervised automatic smoke detection . what measures will be put into place and what systemic changes	

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			will be made to ensure that the deficient practice does not recur; All areas requiring electrically supervised automatic smoke detection will and have electrically supervised automatic smoke detection present. . ·how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The “Sprinkler /Fire Suppression System” QAPI audit tool will be completed by the Maintenance Director or Designee to ensure that all areas requiring electrically supervised automatic smoke detection will and have electrically supervised automatic smoke detection present. The “Sprinkler/Fire Suppression System” QAPI audit tool will be completed weekly for one month, and monthly for 3 months. If 100% compliance is not obtained an action plan will be developed. This	

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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 2 receptacles within 6 feet from a sink were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. 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(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms, (2) Kitchens, (3) Rooftops, (4) Outdoors, (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink, (6) Indoor wet locations, (7) Locker rooms with associated showering facilities, (8) Garages, service bays, and similar areas where electrical diagnostic equipment,	K 0511	p="" paraid="2019875007" paraeid="{fb2d89a6-2ef6-4b99-9e82-6ca3770c6162}{152}">what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The electrical receptacle within less than 6 feet of a sink in the main dining room that was not GFCI protected was removed or replaced with a GFCI protected receptacle. 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; All residents have the potential to be affected by this deficient practice. An audit was performed to ensure that all receptacles that require GFCI protection have GFCI protection. what measures will be put into place and what systemic changes will be made to ensure	08/23/2023

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	electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 30 residents in the main dining room. Findings include: Based on observation the Maintenance Director on 07/31/23 at 12:05 p.m., there were two electric receptacles less than 6 feet from a sink in the main dining room. The electric receptacle closest to the sink was GFCI protected, but the electric receptacle five feet from the sink was not GFCI protected when tested. Based on interview at the time of observation, the Maintenance Director agreed the electric receptacle five feet from the sink was not GFCI protected and provided the measurement of five feet. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		that the deficient practice does not recur; All receptacles that require GFCI protection will have and maintain GFCI protection. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The “Gas and Electrical” QAPI audit tool will be completed by the Maintenance Director or Designee to ensure all receptacles that require GFCI protection will have and maintain GFCI protection. The “Gas and Electrical” QAPI audit tool will be completed weekly for one month, and monthly for 3 months. If 100% compliance is not obtained an action plan will be developed. This information will be presented monthly to the QAPI committee.	
K 0761 SS=E Bldg. 01	#1.) Based on observation and interview, the facility failed to ensure 1 of 4 smoke barrier doors are routinely inspected and repaired as part of the facility maintenance program. This deficient practice could affect 33 residents in two smoke compartments. Findings include:	K 0761	·p paraid="1048304453" paraeid="{0361d5be-97b3-4745-a1c9-0fa8aef3ab8b}{46}" >what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	08/23/2023

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	155322	A. BUILDING 01 B. WING	07/31/2023

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	Based on observation with the Maintenance Director on 07/31/23 at 11:37 a.m., the 200-hall smoke doors were damaged, had a ¾ inch hole through the one of the doors, and the astragals were falling off the doors. Based on interview at the time of observation, the Maintenance Director agreed the smoke doors were damage and needed to be repaired. #2.) Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 1 of 1 oxygen transfilling room fire doors were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so		The 200 hall smoke doors that were noted as damaged were repaired. The oxygen transfer and filling room door was inspected and found to be in working order. 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; All residents have the potential to be affected by this deficient practice. All smoke doors were inspected to ensure that they were in good repair and working order. The oxygen transfer and filling room door was inspected and found to be in good repair and working order. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All smoke barrier doors will be routinely inspected and repaired	

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	equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on record review of the with the Maintenance Director on 07/31/23 at 10:50 a.m., no documentation for the oxygen transfilling room fire door was available for review. Based on observation at 12:30 a.m. there was a one-hour fire door to the oxygen transfilling room. Based on interview at the time of records review and observation, the Maintenance Director stated the fire door was not inspected within the last year. The findings were reviewed with the Administrator and Maintenance Director at the exit conference.		as a part of the facility maintenance program. The oxygen transfer and filling room door will be inspected and repaired annually. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The “Smoke Barrier/Hazardous Area Doors” QAPI audit tool will be completed by the Maintenance Director or Designee to ensure that all such doors are functional and tested per requirement. The “Smoke Barrier/Hazardous Area Doors” QAPI audit tool will be completed weekly for one month, and monthly for 3 months. If 100% compliance is not obtained an action plan will be developed. This information will be presented monthly to the QAPI committee.	

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	3.1-19(b)			
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 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 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 2 residents in room 211. Findings include:	K 0920	p="" xml: paraid="1876826241" paraeid="{2366af42-1628-4043-8360-694233b225e3}{180}">what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The electrical extension cord noted to be in use in room 211	08/23/2023

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	Based on observation with the Maintenance Director on 07/31/23 at 11:44 a.m., in room 211 there was an extension cord in use. Based on interview at the time of observation, the Maintenance Director agreed an extension cord was in use in room 211. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		was removed. 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; All residents have the potential to be affected by this deficient practice. An audit was performed to ensure that no flexible cords were being used as a substitute for fixed wiring. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director will perform daily audits to ensure that no flexible cords are being used as a substitute for fixed wiring. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The “Gas and Electrical” QAPI audit tool will be completed by the Maintenance Director or Designee to ensure that no flexible cords are being used as a substitute for fixed wiring. The “Gas and Electrical” QAPI audit tool will be completed weekly for one month, and monthly for 3 months. If 100% compliance is not obtained an action plan will be developed. This information will be presented monthly to the QAPI committee.	

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K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage 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			

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	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)			
	#1.) Based on observation and interview, the facility failed to ensure 5 of 12 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. 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 25 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 07/31/23 at 12:31 p.m., Five 'E' type oxygen cylinders were standing upright on the floor of the oxygen storage/trans-filling room and were not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of observation, the Maintenance Director acknowledged five 'E' type oxygen cylinders in the oxygen storage/trans-filling room were not properly chained or supported in a proper cylinder stand or cart. #2.) Based on observation and interview, the facility failed to ensure 12 of 12 full and empty oxygen cylinders were separated and marked to avoid confusion. This deficient practice could affect up to 25 residents in one smoke	K 0923	p="" xml: paraid="427798405" paraeid="{acfa173a-c9d9-4f05-9314-c2b05c67af27}{246}">what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The five (5) E-type cylinders were either chained or supported in a proper cylinder stand or cart. The 12 full and empty oxygen cylinders were separated and marked as full or empty. 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; All residents have the potential to be affected by this deficient practice. An audit was performed to ensure that all cylinders were stored properly and separated into empty and full labels. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director will perform daily audits to ensure that all cylinders were stored properly and separated into empty and full labels. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be	08/23/2023

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	compartment. Findings include: Based on observations with the Maintenance Director on 07/31/23 at 12:31 p.m., the oxygen storage room contained full and empty oxygen cylinders, but the cylinders were mixed together and not marked as full or empty. Based on interview at the time of observation, the Maintenance Director stated the cylinders were not marked as full and empty. The findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		put into place; and The “Gas and Electrical” QAPI audit tool will be completed by the Maintenance Director or Designee to ensure that all cylinders were stored properly and separated into empty and full labels. The “Gas and Electrical” QAPI audit tool will be completed weekly for one month, and monthly for 3 months. If 100% compliance is not obtained an action plan will be developed. This information will be presented monthly to the QAPI committee.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure transfilling of oxygen took place in 1 of 1 oxygen transfilling rooms that are separated from any portion of a facility by ensuring the door to the transfilling room is	K 0927	p="" xml: paraid="196360342" paraeid="{b83a7414-8fa2-4463-8559-0b09af299457}{238}">what corrective action(s) will be accomplished for those residents	08/23/2023

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	self-closing and latches into the door frame in accordance with NFPA 99 2012 edition 11.5. This deficient practice could affect up to 25 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 07/31/23 at 12:31 p.m., when the Maintenance Director opened the door to the oxygen transfilling room there was a magnet strip placed over the strike plate preventing the door from latching into the frame. Based on interview at the time of observation, the Maintenance Director agreed the door was not latched into the frame and removed the magnet strip. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		found to have been affected by the deficient practice; The magnet strip placed over the strike pad to the oxygen transfilling room was removed allowing the door to latch into the frame. 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; All residents have the potential to be affected by this deficient practice. A keypad was placed on the transfilling door room in place of a keyed lock, will allow staff to access the room with a code instead of a key. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director will perform daily audits to ensure that obstructions are which may prevent the oxygen transfilling door from latching into its frame. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The “Gas and Electrical” QAPI audit tool will be completed by the Maintenance Director or Designee to ensure that no obstructions are present which may prevent the oxygen transfilling door from latching into its The “Gas and Electrical” QAPI audit tool will be completed	

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			weekly for one month, and monthly for 3 months. If 100% compliance is not obtained an action plan will be developed. This information will be presented monthly to the QAPI committee.	