STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155462	A. BUILDING -- B. WING	08/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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: 08/16/22 Facility Number: 000494 Provider Number: 155462 AIM Number: 100291450 At this Emergency Preparedness survey, Swiss Villa Nursing and Rehabilitation was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 72 certified beds. At the time of the survey, the census was 52. Quality Review completed on 08/17/22	E 0000		
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: 08/16/22 Facility Number: 000494 Provider Number: 155462 AIM Number: 100291450 At this Life Safety Code survey, Swiss Villa	K 0000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or an agreement with the deficiencies or conclusions contained in the Department's inspection report. We respectfully request the Department accept this plan as our facility's compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Nursing and Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code, (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridor and has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 72 and had a census of 52 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility storage were sprinklered. Quality Review completed on 08/17/22		We also request the Department consider an IDR request of citation K521. A HVAC Damper Inspection was completed on 3/20/2020. All dampers are identified on the inspection report. Lastly, we respectfully request paper compliance/desk review of all citations as none are deemed immediate jeopardy. Please contact Megan Lengerich, HFA @ 812-427-2803 with any questions. Thank you for your time.	
K 0211 SS=F 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 record review, observation and interview; the facility failed to maintain the means of egress free from obstructions in 4 of 9 means of egress. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following	K 0211	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · No residents, staff or	09/01/2022

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	conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all residents, staff and visitors if needing to exit the facility. Findings include: Based on review of "Emergency Operations Plan: Fire/Explosion Emergency Action Plan" (E.O.P.) documentation with the Maintenance Supervisor and the Director of Nursing (D.O.N.) during record review from 10:15 a.m. to 12:55 p.m. on 08/16/22, the written fire safety plan did not address the relocation of wheeled equipment during a fire or similar emergency. The aforementioned fire safety plan is part of the facility's Emergency Preparedness Program documentation which was documented as the most recent review occurring on 09/20/21. Based on interview at the time of record review, the D.O.N. did a key word search for wheeled equipment on a computer file version of the E.O.P. which was dated 02/04/19. Based on interview at the time of interview at the time of record review, the D.O.N. and the Maintenance Supervisor agreed the reference to relocating wheeled equipment in the computer file version dated 02/14/19 was not included in the current written fire safety plan documentation dated 09/20/21.		visitors were affected by the alleged deficient practice.· Education regarding K211 and the requirement to maintain a 60-inch egress in corridors and wheeled equipment to be moved during a fire or similar emergency was completed with facility staff on 8/25/22.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**· A review of facility that egresses are clear per K211 was completed on 8/25/22. No concerns were identified. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**- The EOP binder was updated to match the EOP electronic version. Items are stored out of corridors to ensure a 60-inch egress throughout the facility. - The Maintenance Supervisor/designee will audit of facility egresses to ensure a 60-inch egress in all corridors. This audit will be completed daily X 2 weeks, weekly X 6 weeks, then monthly X 10 months. The results will be documented on K211/K711 Audit Tool.- Any discrepancy will be immediately corrected.**How the corrective action (s) will be monitored to ensure the**	

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	Based on observations with the Maintenance Supervisor during a tour of the facility from 12:55 p.m. to 2:45 p.m. on 08/16/22, a large Hoyer lift was stored in the corridor up against the wall outside Room 106 and was not in use. The Hoyer lift extended 28 inches into the eight foot wide corridor. A Hoyer lift was also stored in the corridor outside Room 306. A wheeled plastic chest of drawers was stored in the corridor outside Room 104 and Room 208. A wheeled blood pressure device was stored in the corridor across from the 300 Hall nurse's station. Wheelchairs which were not in use were stored in the corridor outside Room 204, Room 208, Room 302 and Room 306. Based on interview at the time of the observations, the Maintenance Supervisor agreed the aforementioned corridor storage of wheeled equipment did not maintain the means of egress free from obstructions. This finding was reviewed with the Maintenance Supervisor during the exit conference. 3.1-19(b)		**deficient practice will not recur, i.e., what quality assurance program will be put into place?-** The Executive Director/designee will review the K211 audit records to ensure the audit has been completed and documented. The ED/Designee will complete these reviews monthly X 12 months.- The results of the ED/designee review will be forwarded to the QAPI committee for review and recommendation.- Non-compliance will be addressed including use of progressive discipline up to and including termination.	
K 0222 SS=E 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			

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	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. 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.			

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	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 1 of 11 exits 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 Section 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 20 residents, staff and visitors if needing to exit the facility by using the exit door set to the outside of the facility in the Main Dining Room. Findings include: Based on observations with the Maintenance Supervisor during the initial walk through of the facility from 9:55 a.m. to 10:15 a.m. on 08/16/22, the exit door set to the outside of the facility in the Main Dining Room could be opened by entering a code into a keypad at the exit door set but the code was not posted at the exit door set. Based on observations with the Maintenance Supervisor at 2:20 p.m. on 08/16/22, the exit door set to the outside of the facility in the Main Dining Room still did not have the code posted at the keypad for the Main Dining Room exit door set. The	K 0222	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · No residents, staff or visitors were affected by the alleged deficient practice. · Education regarding K222 and requirement for signage to aide in coding out of exit doors was completed with facility staff on 8/25/22. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · A review of the facility exit doors was completed on 8/25/22 to ensure signage to aide in coding out of the exit doors was present. No concerns were identified. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	09/01/2022

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	Maintenance Supervisor entered the code into the keypad which released both doors to open. Based on interview at the time of the observations, the Maintenance Supervisor stated not all residents in the facility have a clinical diagnosis to be in a secure wing or facility and agreed the code was not posted at the exit door set to the outside of the facility in the Main Dining Room. This finding was reviewed with the Maintenance Supervisor during the exit conference. 3.1-19(b)		· Signs are present at all exits reflecting exit code instructions. · The Maintenance Supervisor/designee will review that signs reflecting exit code instructions are present at all exit doors. The review will be completed weekly X 8 weeks, then monthly X 10 months. The results will be documented on the K222 Audit Tool. · Any discrepancy will be immediately corrected. **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?** · The Executive Director/designee will review the K222 Audit Tool monthly X 12 months. · The results of the ED/designee review will be forwarded to the QAPI committee for review and recommendation. · Non-compliance will be addressed including use of progressive discipline up to and including termination.	
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation			

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	or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure egress lighting for 1 of 11 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect over 10 residents, staff and visitors if exiting the facility from the 500 Hall. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 12:55 p.m. to 2:45 p.m. on 08/16/22, one of two light bulbs in the exit means of egress outside the 500 Hall exit door nearest the Therapy Room corridor door was burned out. Based on interview at the time of the observations, the Maintenance Supervisor agreed one of the two light bulbs in the aforementioned exit discharge was burned out. This finding was reviewed with the Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0281	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · No residents, staff or visitors were affected by the alleged deficient practice. · Education regarding K281 illumination of means of egress was completed with facility staff on 8/25/22. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · A review was completed on 8/25/22 to ensure no issues with illumination of means of egress. No concerns were identified. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The two light bulbs on the 500-hall outside the Therapy Gym were replaced prior to surveyor exit on 8/16/2022. · The Maintenance Supervisor/designee will audit that illumination means of egress are in good repair with no burnt-out bulbs or issues. This review will be completed weekly X 12 months. The results of this review will be	09/01/2022

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			documented in TELS. · Any discrepancy will be immediately corrected. **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?** · The Executive Director/designee will review TELS records monthly X 12 months. · The results of the ED/designee review will be forwarded to the QAPI committee for review and recommendation. · Non-compliance will be addressed including use of progressive discipline up to and including termination.	
K 0321 SS=F Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of			

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	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 1 of over 10 hazardous areas such as fuel-fired heater rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 12:55 p.m. to 2:45 p.m. on 08/16/22, numerous holes and ceiling penetrations were noted in the ceiling of the Main Mechanical Room. The Main Mechanical Room contained the facility's main electrical panels, circuit breaker panels for electrical systems on the emergency generator and also housed the facility's dry sprinkler system riser. The Main Mechanical Room also contained a natural gas fired water heater. The annular space surrounding numerous metal conduits	K 0321	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · No residents, staff or visitors were affected by the alleged deficient practice. · Education regarding K321 smoke barriers must separate other spaces from hazardous areas was completed with the Maintenance Supervisor on 8/25/22. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · A review was completed on 8/25/22 to ensure hazardous areas are separated from other areas. No concerns were	09/01/2022

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	penetrating the ceiling of the room above the wall mounted electrical panel identified as "Mickey's Fuse Box" were not firestopped. The annular space surrounding the dry sprinkler system riser pipe which penetrated the ceiling was also not firestopped. The annular space surrounding a ceiling mounted sprinkler which was near the sprinkler system riser exposed the attic above. A hole was noted in the ceiling in the corner of the room above the corridor door to the room which was also not firestopped. Based on interview at the time of the observations, the Maintenance Supervisor agreed the openings in the ceiling of the aforementioned room did not separate this hazardous areas from other spaces with smoke resistant partitions and doors. This finding was reviewed with the Maintenance Supervisor during the exit conference. 3.1-19(b)		identified. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The identified conduits and ceiling penetrations in the main mechanical room are fire stopped/sealed. · The Maintenance Supervisor/designee will audit that penetrations are sealed to comply with K321. This review will be completed monthly X 12 months. The results of this audit will be documented on the K321/K372 Audit Tool. · Any discrepancy will be immediately corrected. **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?** · The Executive Director/designee will review the K321/K372 Audit Tool monthly X 12 months. · The results of the ED/designee review will be forwarded to the QAPI committee for review and recommendation. · Non-compliance will be addressed including use of progressive discipline up to and including termination.	

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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 record review and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice	K 0353	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · No residents, staff or visitors were affected by the alleged deficient practice. · Education regarding K353 sprinkler system maintenance was completed with the Maintenance Supervisor on 8/25/22. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · A review was completed on	09/01/2022

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SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

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	could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the sprinkler system inspection contractor's "Form for Inspection, Testing and Maintenance of Dry Pipe Fire Sprinkler Systems" documentation dated 04/04/22 with the Maintenance Supervisor during record review from 10:15 a.m. to 12:55 p.m. on 08/16/22, deficiencies were noted for the facility's sprinkler system during the inspection for the facility. The "Deficiency Summary" section of the 04/04/22 sprinkler system inspection report stated "Air maintenance device is out of service and needs to be replaced". Based on interview at the time of record review, the Maintenance Supervisor provided an approved "Capital Expenditure Request" dated 04/11/22 to replace the air maintenance device but stated the replacement device has not yet been installed. This finding was reviewed with the Maintenance Supervisor during the exit conference. Based on interview at the time of the exit conference, the Maintenance Supervisor stated the air maintenance device does function and is operating correctly but has not been replaced. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the ceiling construction in the corridor in 1 of 9 smoke compartments. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a		8/25/22 to ensure recommended sprinkler repairs are completed. No concerns were identified. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The recommended repairs to the AMD was completed by facility vendor (IEI) on 8/31/22. The ceiling tile around the Exit sign conduit outside the 200-hall spa was repaired on 8/25/22. · The Maintenance Supervisor/designee will audit that sprinkler repairs are completed as recommended to comply with K353. This review will be completed monthly X 12 months. The results of this audit will be documented on the K353 Audit Tool. · Any discrepancy will be immediately corrected. **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?** · The Executive Director/designee will review the K353 Audit Tool monthly X 12 months. · The results of the ED/designee review will be forwarded to the QAPI committee for review and recommendation. · Non-compliance will be addressed including use of	

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	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 10 residents, staff, and visitors in the vicinity of the Spa by Room 202. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 12:55 p.m. to 2:45 p.m. on 08/16/22, a two inch in diameter hole was noted in the suspended ceiling tile above the exit sign in the corridor above the corridor door set by the Spa by Room 202. The hole exposed the electrical conduit for the exit sign. Based on interview at the time of the observations, the Maintenance Supervisor agreed a hole was noted in the suspended ceiling tile above the exit sign by the Spa by Room 202. This finding was reviewed with the Maintenance Supervisor during the exit conference. 3.1-19(b)		progressive discipline up to and including termination.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or			

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	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 4 of over 50 corridor doors 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. Findings include: Based on observations with the Maintenance	K 0363	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · No residents, staff or visitors were affected by the alleged deficient practice. · Education regarding K363 and no impediments to closing	09/01/2022

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	Supervisor during a tour of the facility from 12:55 p.m. to 2:45 p.m. on 08/16/22, the ceiling mounted track for the privacy curtain for the resident bed nearest the corridor door was installed such that the privacy curtain was in the path of the swing of the corridor door to resident Room 204, Room 206, Room 302 and Room 308. The privacy curtain was fully opened in each room and prevented the corridor door to each of the four resident sleeping rooms from fully closing and latching into the door frame. In addition, the resident bed nearest the corridor door to Room 302 was also in the swing of the path of closure for the door and also prevented the door from closing and latching into the door frame. Based on interview at the time of the observations, the Maintenance Supervisor agreed the privacy curtain in the aforementioned rooms were hung in the path of the swing of the corridor door to the room and would not ensure the door would close and latch into the door frame. This finding was reviewed with the Maintenance Supervisor during the exit conference. 3.1-19(b)		and latching of doors can exist in the facility. Staff were education to store privacy curtains at the far end of resident rooms (opposite the doorway) or behind the curtain retainers inside the doorway such that the privacy curtains do not obstruct the swinging path of the doorway. This education was completed with facility staff on 8/25/22. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · A review was completed on 8/25/22 to ensure no impediments to closing and latching of doors exists. Concerns were immediately corrected. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Curtain retainers were installed in resident rooms to allow for privacy curtains to be stored out of the swing path of doorways. · The Maintenance Supervisor/designee will audit that no impediments to closing and latching of doors exist. This review will be completed weekly X 8 weeks, then monthly X 10 months. The results of this audit will be documented on the K363 Audit Tool. · Any discrepancy will be	

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			immediately corrected. **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?** · The Executive Director/designee will review the K363 Audit Tool monthly X 12 months. · The results of the ED/designee review will be forwarded to the QAPI committee for review and recommendation. · Non-compliance will be addressed including use of progressive discipline up to and including termination.	
K 0372 SS=F 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. 1. Based on observation and interview, the facility failed to ensure openings through 1 of 1 ceiling smoke barriers was protected to maintain the fire	K 0372	**What corrective action(s) will be accomplished for those residents found to have been**	09/01/2022

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	resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 12:55 p.m. to 2:45 p.m. on 08/16/22, numerous holes and ceiling penetrations were noted in the ceiling of the Main Mechanical Room. The Main Mechanical Room contained the facility's main electrical panels, circuit breaker panels for electrical systems on the emergency generator and also housed the facility's dry sprinkler system riser. The Main Mechanical Room also contained a natural gas fired water heater. The annular space surrounding numerous metal conduits penetrating the ceiling of the room above the wall mounted electrical panel identified as "Mickey's Fuse Box" were not firestopped. The annular space surrounding the dry sprinkler system riser pipe which penetrated the ceiling was also not firestopped. The annular space surrounding a ceiling mounted sprinkler which was near the sprinkler system riser exposed the attic above. A hole was noted in the ceiling in the corner of the room above the corridor door to the room which		**affected by the deficient practice?** · No residents, staff or visitors were affected by the alleged deficient practice. · Education regarding K372 smoke barriers must separate other spaces from hazardous areas was completed with the Maintenance Supervisor on 8/25/22. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · A review was completed on 8/25/22 to ensure smoke barriers are sealed per K372. Concerns were immediately corrected. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The identified conduits and ceiling penetrations in the main mechanical room and the attic access outside of medical records office were fire stopped/sealed. · The Maintenance Supervisor/designee will audit that penetrations are sealed to comply with K372. This review will be completed monthly X 12 months. The results of this audit will be documented on the K/321/K372 Audit Tool. · Any discrepancy will be immediately corrected.	

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	was also not firestopped. Based on interview at the time of the observations, the Maintenance Supervisor agreed the openings in the ceiling of the aforementioned room did not separate this hazardous areas from other spaces with smoke resistant partitions and doors. This finding was reviewed with the Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 6 smoke barrier walls were protected to maintain the fire resistance 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 50 residents, staff and visitors in the vicinity of the corridor door set by th Medical Records office. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 12:55 p.m. to 2:45 p.m. on 08/16/22, an open ended four inch in diameter conduit which penetrated the smoke barrier wall in the attic above the corridor door set by the Medical Records office was not firestopped. The conduit contained numerous gray cables. The annular space surrounding the conduit was also not firestopped. Based on interview at the time of the observations, the Maintenance Supervisor agreed the aforementioned openings in the attic smoke barrier wall were not protected to maintain the fire resistance of the smoke barrier.		**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?** · The Executive Director/designee will review the K321/K372 Audit Tool monthly X 12 months. · The results of the ED/designee review will be forwarded to the QAPI committee for review and recommendation. · Non-compliance will be addressed including use of progressive discipline up to and including termination.	

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	This finding was reviewed with the Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation and interview; the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance within the most recent four year period in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning 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	K 0521	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · No residents, staff or visitors were affected by the alleged deficient practice. · Education regarding K521 requirement for 4-year inspections of HVAC dampers was completed with the Maintenance Supervisor on 8/25/22. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · A review was completed on 8/25/22 to ensure documentation of the March 20, 2020 completed damper inspection is on file and available for review at the facility. **What measures will be put into place or what systemic changes you will make to ensure that the deficient**	09/01/2022

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	the fire damper shall be verified and corrected as required. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Maintenance Supervisor from 10:15 a.m. to 12:55 p.m. on 08/16/22, documentation of fire damper inspections conducted within the most recent four year period was not available for review. Based on interview at at the time of record review, the Maintenance Supervisor provided a "Fire Damper" floor plan for the facility which listed two fire damper locations in the facility but the Maintenance Supervisor agreed the floor plan documentation did not provide the date of the most recent inspection and necessary maintenance. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:55 p.m. to 2:45 p.m. on 08/16/22, two additional fire damper locations which were not included on the "Fire Damper" floor plan were noted. Documentation affixed to the fire damper in HVAC ductwork in the corridor outside Room 503 and in HVAC ductwork in the sitting area in the 500 Hall by Room 500 did not provide the date of the most recent inspection and necessary maintenance. Based on interview at the time of record review and of the observations, the Maintenance Supervisor agreed documentation of fire damper inspections conducted within the most recent four year period was not available for review. This finding was reviewed with the Maintenance Supervisor during the exit conference. 3.1-19(b)		**practice does not recur?** · The next 4-year damper inspection will be completed prior to March 2024. · The Maintenance Supervisor/designee will review that record of the 3/20/22 inspection is on file in the Life Safety Binder and available for review. The Maintenance Supervisor/designee will ensure the next inspection is completed prior to March 2024 and documentation of the damper inspections is recorded in TELS Q 4 years. · Any discrepancy will be immediately corrected. **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?** · The Executive Director/designee will review that 4-year damper inspections are completed Q 4 years and documentation of the inspections are on hand in TELS and facility Life Safety Binder. · The results of the ED/designee review will be forwarded to the QAPI committee for review and recommendation. · Non-compliance will be addressed including use of progressive discipline up to and including termination.	

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			We respectfully request an IDR review of this citation. We request this citation be deleted. On March 20, 2020 a facility damper inspection was completed. A record was on hand on the date of the Life Safety inspection. The 4-year inspections are completed timely and the inspections appropriately identify all dampers. The 2567 references a Fire Damper Floor Plan. No such record exists the document referenced was a handwritten note-not an official facility record. A system is in place to ensure timely completion of these inspection. The facility uses TELS PM tracking system to ensure the facility staff are alerted to the need for and complete the damper inspections timely. The next inspection will be completed prior to March 2024 (or per K521-should the requirement change).	
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required			

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	of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review, observation and interview; the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 inches. (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants.	K 0711	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · No residents, staff or visitors were affected by the alleged deficient practice. · Education regarding K711 that no items may be stored in corridors, the fire safety plan identifies the location of smoke/fire doors, and the EOP evacuation procedure addresses wheeled equipment procedure during an emergency. This education was completed with facility staff on 8/25/22. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · A review was completed on 8/25/22 to ensure no items are stored in corridors, the fire safety plan was updated to identify the location of smoke/fire doors, and the EOP binder was updated to the include evacuation procedure for wheeled equipment during an emergency. Concerns were immediately corrected. **What measures will be put into**	09/01/2022

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	155462	A. BUILDING 01 B. WING	08/16/2022

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	Findings include: Based on review of "Emergency Operations Plan: Fire/Explosion Emergency Action Plan" (E.O.P.) documentation with the Maintenance Supervisor and the Director of Nursing (D.O.N.) during record review from 10:15 a.m. to 12:55 p.m. on 08/16/22, the written fire safety plan did not address the relocation of wheeled equipment during a fire or similar emergency. The aforementioned fire safety plan is part of the facility's Emergency Preparedness Program documentation which was documented as the most recent review occurring on 09/20/21. Based on interview at the time of record review, the D.O.N. did a key word search for wheeled equipment on a computer file version of the E.O.P. which was dated 02/04/19. Based on interview at the time of interview at the time of record review, the D.O.N. and the Maintenance Supervisor agreed the reference to relocating wheeled equipment in the computer file version dated 02/14/19 was not included in the current written fire safety plan documentation dated 09/20/21. In addition the written fire safety plan for the facility dated 09/20/21 stated residents would be evacuated during a fire or similar emergency, if necessary, through smoke or fire doors but the fire safety plan documentation did not state the location of smoke or fire doors in the facility. Based on interview at the time of record review, the D.O.N. and the Maintenance Supervisor agreed the current written fire safety plan for the facility did not include the location of smoke or fire doors in the facility. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:55 p.m. to 2:45 p.m. on 08/16/22, a large Hoyer lift was		**place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The identified items were removed from corridors, the EOP binder was updated to include location of smoke/fire doors in the fire safety plan, the EOP binder was updated to include proper handling of wheeled equipment during an evacuation or similar emergency. · The Maintenance Supervisor/designee will audit that corridors remain free of stored items and complies with K711. This review will be completed daily X 2 weeks, weekly X 6 weeks, then monthly X 10 months. The results of this audit will be documented on the K211/K281/K711 Audit Tool. · Any discrepancy will be immediately corrected. **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?** · The Executive Director/designee will review the K211/K281//K711 Audit Tool monthly X 12 months. · The results of the ED/designee review will be forwarded to the QAPI committee for review and recommendation.	

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	stored in the corridor up against the wall outside Room 106 and was not in use. The Hoyer lift extended 28 inches into the eight foot wide corridor. A Hoyer lift was also stored in the corridor outside Room 306. A wheeled plastic chest of drawers was stored in the corridor outside Room 104 and Room 208. A wheeled blood pressure device was stored in the corridor across from the 300 Hall nurse's station. Wheelchairs which were not in use were stored in the corridor outside Room 204, Room 208, Room 302 and Room 306. Based on interview at the time of the observations, the Maintenance Supervisor agreed wheeled equipment not in use was stored in the corridor. This finding was reviewed with the Maintenance Supervisor during the exit conference. 3.1-19(b)		· Non-compliance will be addressed including use of progressive discipline up to and including termination.	
K 0761 SS=E Bldg. 01	Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies 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	K 0761	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · No residents, staff or visitors were affected by the alleged deficient practice. · Education regarding K761 that fire resistance rating plates on fire doors must not be obstructed with paint or other material. This education was completed with the Maintenance Supervisor on 8/25/22. **How will you identify other**	09/01/2022

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	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 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 over 10 residents, staff and visitors in the vicinity of the corridor door set Room 501.		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · A review was completed on 8/25/22 to ensure fire door rating plates are not obstructed with paint or other material. No concerns were identified. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The paint was removed from the fire resistance rating plate on the identified 500 hall fire door. · The Maintenance Supervisor/designee will audit that fire door fire resistance rating plates are visible and comply with K761. This review will be completed monthly X 12 months. The results of this audit will be documented on the K761 Audit Tool. · Any discrepancy will be immediately corrected. **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?** · The Executive Director/designee will review the K761 Audit Tool monthly X 12 months. · The results of the ED/designee review will be	

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	Findings include: Based on review of "Inspection of Swinging Fire Door Assemblies" documentation for inspections conducted within the most recent twelve month period with the Maintenance Supervisor during record review from 10:15 a.m. to 12:55 p.m. on 08/16/22, none of the fire door inspections documented any deficiencies. The fire door inspections were conducted by American Senior Communities. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:55 p.m. to 2:45 p.m. on 08/16/22, the fire resistance rating label on the hinge side of the north fire door in the corridor door set by Room 501 was painted and not legible. Based on interview at the time of the observations, the Maintenance Supervisor agreed the fire resistance rating label was painted at one of the fire door locations. This finding was reviewed with the Maintenance Supervisor during the exit conference. 3.1-19(b)		forwarded to the QAPI committee for review and recommendation. · Non-compliance will be addressed including use of progressive discipline up to and including termination.	
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			

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	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 failed to ensure 4 of 9 cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 1 oxygen storage areas. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.1 states storage for nonflammable gases equal to or greater than 85 cubic meters (3000 cubic feet) shall comply with 5.1.3.3.2 and 5.1.3.3.3. NFPA 99, Section 5.1.3.3.2(7) requires cylinders be	K 0923	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · No residents, staff or visitors were affected by the alleged deficient practice. · Education regarding K923	09/01/2022

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	provided with racks, chains, or other fastenings to secure all cylinders from falling, whether connected, unconnected, full or empty. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room by the 300 Hall nurse's station. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 12:55 p.m. to 2:45 p.m. on 08/16/22, four of nine 'E' type oxygen cylinders were freestanding on the floor in the oxygen storage and transfilling room by the 300 Hall nurse's station and were not properly secured from falling. Five liquid oxygen containers and nine 'E' type oxygen cylinders were stored in the room. Based on interview at the time of the observations, the Maintenance Supervisor agreed the four oxygen cylinders were not supported in a cylinder stand or otherwise secured from falling in the oxygen storage and transfilling room by the 300 Hall nurse's station. This finding was reviewed with the Maintenance Supervisor during the exit conference. 3.1-19(b)		proper storage of O2 equipment was completed with facility staff on 8/25/22. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · A review was completed on 8/25/22 to ensure oxygen tanks were properly stored in the oxygen room. No concerns were identified. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Stands and fixed storage devices are present in the oxygen room to ensure O2 tanks can be properly stored per K923. · The Maintenance Supervisor/designee will audit that oxygen tanks are properly stored and comply with K761. This review will be completed daily X 2 weeks, weekly X 6 weeks, then monthly X 10 months. The results of this audit will be documented on K923/K927 Audit Tool. · Any discrepancy will be immediately corrected. **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?** · The Executive Director/designee will review the	

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			K923/927 Audit Tool monthly X 12 months. · The results of the ED/designee review will be forwarded to the QAPI committee for review and recommendation. · Non-compliance will be addressed including use of progressive discipline up to and including termination.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage locations where transfilling occurs was in accordance with NFPA 99, Health Care Facilities Code. NFPA 99, 2012 Edition, Section 11.5.2.3.1 states oxygen transfilling locations shall include the following: (1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire resistive construction. (2) The area is mechanically vented, is sprinklered, and has ceramic or concrete flooring. (3) The area is posted with signs indicating that	K 0927	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · No residents, staff or visitors were affected by the alleged deficient practice. · Education regarding K927 oxygen trans-fill signage must be present at oxygen room was completed with facility staff on 8/25/22.	09/01/2022

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	transfilling is occurring and that smoking in the immediate area is not permitted. (4) The individual transfilling the container(s) has been properly trained in the transfilling procedures. Section 11.5.3.2.3 states in health care facilities where smoking is prohibited and signs are prominently (strategically) placed at all major entrances, secondary signs with no smoking language shall not be required. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room by the 300 Hall nurse's station. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 12:55 p.m. to 2:45 p.m. on 08/16/22, oxygen transfilling occurs in the oxygen storage and transfilling room by the 300 Hall nurse's station. Four liquid oxygen containers and nine 'E' type oxygen cylinders were stored in the room. This transfilling location was not posted with signage indicating transfilling occurs in the room. Based on interview at the time of the observations, the Maintenance Supervisor agreed the 300 Hall oxygen storage and transfilling room was not posted with signage indicating transfilling occurs in the room. This finding was reviewed with the Maintenance Supervisor during the exit conference. 3.1-19(b)		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · A review was completed on 8/25/22 to ensure oxygen trans-fill signage was present at the oxygen room. No concerns were identified. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Oxygen trans-fill signs are posted inside and outside of the oxygen room door. · The Maintenance Supervisor/designee will audit that the signs are in place to comply with K927. This review will be completed daily X 2 weeks, weekly X 6 weeks, then monthly X 10 months. The results of this audit will be documented on K923/K927 Audit Tool. · Any discrepancy will be immediately corrected. **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?** · The Executive Director/designee will review the K923/927 Audit Tool monthly X 12 months. · The results of the ED/designee review will be	

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			forwarded to the QAPI committee for review and recommendation. · Non-compliance will be addressed including use of progressive discipline up to and including termination.	