STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING -- B. WING	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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: 03/18/24 Facility Number: 000022 Provider Number: 155061 AIM Number: 100274510 At this Emergency Preparedness survey, Envive of Lawrenceburg was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 100 certified beds. At the time of the survey, the census was 50. Quality Review completed on 03/27/24 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Life Safety Survey conducted March 18,2024.	
E 0004 SS=F 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).			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING -- B. WING	03/18/2024

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	The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] 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. .			

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	155061	A. BUILDING -- B. WING	03/18/2024

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	Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Operations Plan" documentation dated 01/13/23 with the Interim Executive Director, the Director of Nursing and the Regional Maintenance Director during record review from 12:05 p.m. to 2:00 p.m. on 03/18/24, documentation for a complete emergency preparedness program reviewed by the facility within the most recent twelve month period was not available for review. The aforementioned plan was dated as being reviewed on 01/13/23 which was not within the most recent twelve month period. Based on interview at the time of record review, the Interim Executive Director agreed 01/13/23 was the date of the most recent review of emergency preparedness program documentation. These findings were reviewed with the Interim Executive Director and the Regional Maintenance Director during the exit conference.	E 0004	E 004 Develop EP Plan, Review and Update Annually CFR(s): 483.73(a EP Plan has been reviewed and updated by the Maintenance director and Executive Director. This deficient practice could affect all residents, staff, and visitors in the facility. The Director of Maintenance has been educated by the Executive Director on E004 EP Plan must be reviewed and updated annually. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. Compliance Date 4-18-24	04/18/2024
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2),			

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	§484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency			

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	155061	A. BUILDING -- B. WING	03/18/2024

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	preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach which was reviewed within the most recent twelve month period and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Operations Plan" documentation dated 01/13/23 with the Interim	E 0006	**E 006** Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) EP Plan that is (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach and (2) included strategies for addressing emergency events identified by the risk assessment has been reviewed and updated by the Maintenance director and Executive Director.	04/18/2024

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	Executive Director, the Director of Nursing and the Regional Maintenance Director during record review from 12:05 p.m. to 2:00 p.m. on 03/18/24, a documented facility-based and community-based risk assessment reviewed by the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Interim Executive Director stated 01/13/23 was the date of the most recent review of emergency preparedness program documentation. These findings were reviewed with the Interim Executive Director and the Regional Maintenance Director during the exit conference.		This deficient practice could affect all residents, staff, and visitors in the facility. The Director of Maintenance has been educated by the Executive Director on E006 EP Plan must be reviewed and updated annually. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. **Compliance Date** 4-18-24	
E 0013 SS=F 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.			

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	*[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 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			

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	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 its emergency preparedness policies annually. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Operations Plan" documentation dated 01/13/23 with the Interim Executive Director, the Director of Nursing and the Regional Maintenance Director during record review from 12:05 p.m. to 2:00 p.m. on 03/18/24, emergency preparedness policies and procedures reviewed within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Interim Executive Director stated 01/13/23 was the date of the most recent review of emergency preparedness program documentation. These findings were reviewed with the Interim Executive Director and the Regional Maintenance Director during the exit conference.	E 0013	**E 013** Development of EP Policies and Procedures CFR(s): 483.73(b) EP Plan Policy and procedures have been reviewed and updated by the Maintenance director and Executive Director. This deficient practice could affect all residents, staff, and visitors in the facility. The Director of Maintenance has been educated by the Executive Director on E013 EP Plan policies and procedures must be reviewed and updated annually. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. **Compliance Date** 4-18-24	04/18/2024
E 0029 SS=F 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			

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	§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 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 develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws which was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Operations Plan" documentation dated 01/13/23 with the Interim Executive Director, the Director of Nursing and the Regional Maintenance Director during record review from 12:05 p.m. to 2:00 p.m. on 03/18/24, documentation for a complete emergency preparedness communication plan reviewed by the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Interim Executive Director stated 01/13/23 was the date of the most recent review of emergency preparedness program documentation. These findings were reviewed with the Interim Executive Director and the Regional Maintenance Director during the exit conference.	E 0029	**E 029** Development of Communication Plan CFR(s): 483.73© EP Communication Plan has been reviewed and updated by the Maintenance director and Executive Director. This deficient practice could affect all residents, staff, and visitors in the facility. The Director of Maintenance has been educated by the Executive Director on E029 EP Plan Communication must be reviewed and updated annually. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. **Compliance Date** 4-18-24	04/18/2024

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E 0036 SS=F 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 §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			

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	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 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 develop and maintain emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants.	E 0036	**E 036** EP Training and Testing CFR(s): 483.73(d) **Immediate Intervention** EP Training and Testing Program has been reviewed and updated by the Maintenance director and	04/18/2024

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	Findings include: Based on review of "Emergency Operations Plan" documentation dated 01/13/23 with the Interim Executive Director, the Director of Nursing and the Regional Maintenance Director during record review from 12:05 p.m. to 2:00 p.m. on 03/18/24, the facility's emergency preparedness training and testing program documentation was not reviewed within the most recent twelve month period. Based on interview at the time of record review, the Interim Executive Director stated 01/13/23 was the date of the most recent review of emergency preparedness program documentation. These findings were reviewed with the Interim Executive Director and the Regional Maintenance Director during the exit conference.		Executive Director. This deficient practice could affect all residents, staff, and visitors in the facility. The Director of Maintenance has been educated by the Executive Director on E029 EP Plan Communication must be reviewed and updated annually. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. **Compliance Date** 4-18-24	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:			

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	155061	A. BUILDING -- B. WING	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

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	(i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:			

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	(i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation			

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	of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in			

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	its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.			

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	(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise			

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	that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is			

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	community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual,			

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	facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The			

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	RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed	E 0039	**E 039 EP** Testing Requirements CFR(s): 483.73(d)(2) **Immediate Intervention** The Director of Maintenance completed the AAR (After Action Report) for the real world event\ facility-based exercise (tornado 4-2-24). This deficient practice could affect all residents, staff, and visitors in the facility. The Director of Maintenance has been educated by the Executive Director on E039 EP Testing Requirements This task will be placed into the Tels Building Management system for future scheduling. Results of these reports will be presented by the Executive Director to the QAPI committee for further recommendations. **Compliance Date** 4-18-24	04/18/2024

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	messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Operations Plan" documentation dated 01/13/23 with the Interim Executive Director, the Director of Nursing and the Regional Maintenance Director during record review from 12:05 p.m. to 2:00 p.m. on 03/18/24, the facility did not document a full-scale exercise that is community-based or an individual, facility-based functional exercise within the most recent two year period. The facility also did not document any actual natural or man-made emergency that required activation of the emergency plan within the most recent two year period. The facility documented an elopement table top exercise on 12/05/23. Based on interview with the Interim Executive Director at 2:00 p.m. on 03/18/24, documentation of a community-based exercise, an individual, facility-based exercise or documentation of an actual natural or man-made emergency that required activation of the emergency plan within the most recent two year period was not available for review. These findings were reviewed with the Interim Executive Director and the Regional Maintenance Director during the exit conference.			
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	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/18/2024 Facility Number: 000022 Provider Number: 155061 AIM Number: 100274510 At this Life Safety Code survey, Envive of Lawrenceburg 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 three story facility with a basement was determined to be of Type II(222) construction and was fully sprinklered except. The facility has a fire alarm system with smoke detection on all levels including the basement, in the corridor, in all areas open to the corridor and in all resident sleeping rooms. Resident sleeping Rooms 101-107 were being used as vent unit bedrooms with a total of 7 vent unit bed locations. The facility has a capacity of 100 and had a census of 50 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing storage services were sprinklered, except the detached outdoor oxygen storage area. Quality Review completed on 03/27/24	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Life Safety Survey conducted March 18,2024.	

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K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 6 exit doors was readily accessible for all residents, staff and visitors per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 15 residents, staff and visitors if needing to exit the facility using the exit door to the lobby outside the first floor Therapy Room. Findings include: Based on observations with the Interim Executive Director and the Regional Director of Facilities during a tour of the facility from 2:00 p.m. to 4:30 p.m. on 03/18/24, the exit door by the entrance door to the Therapy Room on the south side of the facility was equipped with latching hardware and was also equipped with signage indicating the door was a delayed egress door and could be opened after pushing for 15 seconds but the door was not a delayed egress door. Based on interview at the time of the observations, the Regional Director of Facilities stated the door is no longer a delayed egress door and the signage should be removed as you can open the door if you push on the panic hardware affixed to the door.	K 0100	**K 100** General Requirements - Other CFR(s): NFPA 101 No residents were affected by this deficient practice. The Maintenance Director removed signage indicating the door was a delayed egress door from the exit door by the entrance door to the Therapy Room. This deficient practice could affect over 15 residents, staff and visitors if needing to exit the facility using the exit door to the lobby outside the first floor Therapy Room. Also, the latch has been replaced on the corridor door to the second-floor nurses station. It has been tested and now latches properly. This deficient practice could affect over 15 residents, staff and visitors on the second floor. The Maintenance Director has been educated on K100. The Director of Maintenance will perform daily reviews(M-F) for 4 weeks, Weekly reviews for 2 months, monthly reviews for 3 months for a total of 6 months.	04/18/2024

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	These findings were reviewed with the Interim Executive Director and the Regional Director of Facilities during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure corridor doors to 1 of over 40 rooms would close and latch into the door frame per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 15 residents, staff and visitors on the second floor. Findings include: Based on observations with the Interim Executive Director and the Regional Director of Facilities during a tour of the facility from 2:00 p.m. to 4:30 p.m. on 03/18/24, the corridor door to the second floor nurses station by the smoke barrier corridor door set was equipped with a latching mechanism on the door but the door failed to latch into the door frame when tested to close multiple times. The north wall of the nurse's station made the room open to the corridor. Based on interview at the time of the observations, the Regional Director of Facilities agreed the aforementioned corridor door location did not latch into the door frame when tested to close multiple times. These findings were reviewed with the Interim Executive Director and the Regional Director of Facilities during the exit conference. 3.1-19(b)		This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. **Compliance Date** 4-18-24	

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K 0161 SS=F Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach			

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	small floor plan of the building as appropriate. 1. Based on observation and interview, the facility failed to maintain the limited noncombustible rating in accordance with LSC Table 19.1.6.1. This deficient practice could affect all occupants. Findings include: Based on observations with the Interim Executive Director and the Regional Maintenance Director during a tour of the facility from 2:00 p.m. to 4:30 p.m. on 03/18/24, foam was used to firestop numerous penetrations of the load bearing walls inside the "Electrical Panel Generator Control" room in the basement. The penetrations were for electrical conduits associated with the automatic transfer switch and wall mounted electrical panels in the room. In addition, balled tape was inserted into a hole in the ceiling in the corridor outside Room 305 where a former light fixture had been removed. Based on interview at the time of the observations, the Regional Maintenance Director stated the UL listing documentation for the foam was not available for review and agreed the use of foam and balled tape failed to maintain the limited noncombustible rating of the facility. These findings were reviewed with the Interim Executive Director and the Regional Maintenance Director during the exit conference. 3.1-19(b)2. Based on observation and interview, the facility failed to maintain the building construction type was a permitted type as listed in Table 19.1.6.1. Table 19.1.6.1 requires a sprinklered building, three stories in height, to be Type II(111), Type II (222), Type I (332) or Type I (442) construction. This deficient practice could affect over 10 residents, staff and visitors in the basement.	K 0161	**K 161** Building Construction Type and Height CFR(s): NFPA 101 **Immediate Intervention** The Director of Maintenance has applied fire caulk to all penetrations. This deficient practice could affect all occupants. The Director of Maintenance has been educated by the Executive Director on K161. All firewall penetrations shall be filled with NFPA approved fire caulk to prevent smoke and fire from spreading. The Director of Maintenance will perform monthly reviews for 6 months. This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. **Compliance Date** 4-18-24	04/18/2024

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	Findings include: Based on observations with the Interim Executive Director and Regional Maintenance Director during a tour of the facility on 03/18/2024 between 2:00 PM and 4:30 PM, this three story sprinklered building was constructed of concrete block and was determined to be Type II (222) construction. The interior load bearing walls of the closet of the Activities storage in the basement was also concrete block. Penetrations of approximately 1/2 inch or less in the walls around sprinklers and pipes were observed in the following locations: (a) Room 313 (b) Room 201 by the bathroom (c) 2nd floor utility room had 3 penetrations (d) Room 106 (e) Boiler room above breaker panel Additionally, there was a penetration in the kitchen storage room bulkhead of approximately 1 ft by 3 ft which had wood framing. This results in a construction type classification of Type V(000) which is not allowed for a three story, existing sprinklered building. Based on interview at the time of the observations, the Regional Maintenance Director agreed there were penetrations in the walls at the aforementioned locations and provided the measurement of the penetration in the kitchen storage room. This finding was reviewed with the Interim Executive Director and Regional Maintenance Director during the exit conference. 3.1-19(b)			

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K 0200 SS=D Bldg. 01	NFPA 101 Means of Egress Requirements - Other Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress 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. 18.2, 19.2 Based on observation and interview, the facility failed to ensure 1 of 1 marketing closet doors and 1 of 1 bathrooms in the beauty salon in the basement was equipped with only 1 locking mechanism which was able to be unlocked from the inside in the case of fire or other emergencies in accordance with LSC 7.1.10.1. This deficient practice could affect staff. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Interim Executive Director on 03/18/2024 between 2:00 PM and 4:30 PM, the marketing closet was observed to have a combination lock on the door and the bathroom door in the beauty salon had a sliding door lock on the inside of the door. Based on interview at the time of observations, the Regional Maintenance Director agreed the marketing closet had a combination lock and the bathroom closet in the beauty salon had a slide lock. This finding was reviewed with the Interim Executive Director and Regional Maintenance Director at the exit conference. 3.1-19(b)	K 0200	**K 200** Means of Egress Requirements – Other CFR(s): NFPA 101 No residents were affected by this deficient practice. The Maintenance Director removed the locks on the marketing closet and the salon bathroom door. The deficient practice could affect staff. The Maintenance Director has been educated on K200 Means of Egress Requirements. **Compliance Date** 4-18-24	04/18/2024

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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 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			

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	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 1 of 1 restrooms in 1 of over 40 resident sleeping rooms were not equipped with locks which cannot be opened from the egress side. LSC Section 7.2.1.5.1 states door leaves shall be arranged to be opened readily from the egress side. Locks, if provided, shall not require the use of a key, tool, or special knowledge or effort for operation from the egress side. This deficient practice could affect 1 resident of staff. Findings include: Based on observations with the Interim Executive Director and the Regional Maintenance Director	K 0222	**K 222** Egress Doors CFR(s): NFPA 101 No residents were affected by this deficient practice. The Maintenance Director removed the sliding bolt from the door. This deficient practice could affect 1 resident or staff. The Maintenance Director has been educated on K222 Egress Doors. **Compliance Date** 4-18-24	04/18/2024

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	during a tour of the facility from 2:00 p.m. to 4:30 p.m. on 03/18/24, a sliding bolt was affixed to the door to the bathroom in resident sleeping Room 307. Based on interview at the time of the observations, the Regional Maintenance Director agreed a sliding bolt was affixed to the door to the bathroom in resident sleeping Room 307. These findings were reviewed with the Interim Executive Director and the Regional Maintenance Director during the exit conference. 3.1-19(b)			
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation and interview, the facility failed to meet the clear width requirement for 1 of 8 corridors or met an exception per 19.2.3.4(4). LSC Section 19.2.3.4(4) states 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	K 0232	**K 232** Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 No residents were affected by this deficient practice. The Maintenance Director removed the Hoyer lift from the corridor. This deficient practice could affect 10 residents, staff and visitors if needing to exit the facility from the third floor. The Maintenance Director has been educated on K232 stating the width of aisles or corridors shall be at least 6 feet.	04/18/2024

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	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 over 10 residents, staff and visitors if needing to exit the facility from the third floor. Findings include: Based on observations with the Interim Executive Director and the Regional Maintenance Director during a tour of the facility from 2:00 p.m. to 4:30 p.m. on 03/18/24, one Hoyer lift was stored in the corridor outside resident sleeping Room 303 on the third floor. The corridor outside the resident sleeping rooms measured seven feet wide as estimated by the Regional Maintenance Director who also stated the Hoyer lift storage projected 2.5 feet into the corridor. Based on interview at the time of the observations, the Regional Maintenance Director agreed the aforementioned wheeled equipment storage reduced the clear and unobstructed corridor width of the third floor corridor to less than 60 inches. These findings were reviewed with the Interim Executive Director and the Regional Maintenance Director during the exit conference. 3.1-19(b)		The Director of Maintenance will perform daily reviews(M-F) for 4 weeks, Weekly reviews for 2 months, monthly reviews for 3 months for a total of 6 months. This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. **Compliance Date** 4-18-24	
K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of			

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	at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. 1. Based on observation and interview, the facility failed to maintain protection of 2 of 2 interior stairwells. LSC 19.3.1 requires vertical openings shall be enclosed or protected in accordance with Section 8.6. LSC 8.6.1 requires every floor that separates stories in a building shall be constructed as a smoke barrier. LSC 8.6.5 states see 7.1.3.2.1 for enclosures of exits. LSC 7.1.3.2.1 states the separation shall have a minimum 1-hr fire resistance rating where the exit connects three stories or less. This deficient practice could affect over 15 residents, staff and visitors on the third floor. Findings include: Based on observations with the Interim Executive Director and the Regional Maintenance Director during a tour of the facility from 2:00 p.m. to 4:30 p.m. on 03/18/24, the latching mechanism on the stairwell door by Room 305 and by Room 311 on the third floor was removed which caused each of the two stairwell doors to not latch into the door frame when tested to close multiple times. Each stairwell door was equipped with a 90-minute fire resistance rating label affixed to the hinge side of the door. Based on interview at the time of the observations, the Regional Maintenance Director agreed the missing latching mechanism for the two stairwell doors did not maintain the fire resistance rating of the stairwell vertical openings. These findings were reviewed with the Interim	K 0311	**K 311** Vertical Openings - Enclosure CFR(s): NFPA 101 No residents were affected by this deficient practice. The Maintenance Director added latching mechanisms to the stairwell doors by Room 305 and by Room 311 on the 3rd floor. Also, the one foot by one foot opening in the concrete block shaft wall in the bathroom of Room 109 was properly repaired. This deficient practice could affect over 7 residents, staff and visitors in the vicinity of Room 109. The Maintenance Director has been educated on K311 Vertical Openings - Enclosures. The Director of Maintenance will perform daily reviews(M-F) for 4 weeks, Weekly reviews for 2 months, monthly reviews for 3 months for a total of 6 months. This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. **Compliance Date** 4-18-24	04/18/2024

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	Executive Director and the Regional Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain protection of all interior pipe shafts. LSC 19.3.1 requires vertical openings shall be enclosed or protected in accordance with Section 8.6. 19.3.1.1 states where enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating. LSC 8.6.3(1) states where penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, pneumatic tube conveyors, and similar items to accommodate electrical, mechanical, plumbing, and communications systems are protected in accordance with 8.3.5.1 and 8.5.6. 8.5.6.2 states penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the transfer of smoke. This deficient practice could affect over 7 residents, staff and visitors in the vicinity of Room 109. Findings include: Based on observations with the Interim Executive Director and the Regional Maintenance Director during a tour of the facility from 2:00 p.m. to 4:30 p.m. on 03/18/24, the interior shaft housing piping for a boiler which had been formerly used for heating but is no longer in use due to a PTAC in resident sleeping Room 109 was noted. The shaft			

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	extends from the basement ceiling to the underside of the third floor ceiling and penetrates the second floor. A one foot by two foot opening in the concrete block shaft wall was noted in the bathroom for resident sleeping Room 109. The opening in the bathroom wall did not ensure the shaft was constructed with not less than a 1-hour fire resistance rating and was not protected by a system or material capable of restricting the transfer of smoke. Based on interview at the time of the observations, the Regional Maintenance Director stated the sleeping room had undergone recent renovations and agreed the opening in the shaft wall in the bathroom failed to maintain the fire resistance rating of the interior vertical opening. These findings were reviewed with the Interim Executive Director and the Regional Maintenance Director during the exit conference. 3.1-19(b)			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.			

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	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 2 of over 7 hazardous areas such as combustible storage rooms/spaces (over 50 square feet) 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 over 5 residents, staff and visitors in the basement. Findings include: Based on observations with the Interim Executive Director and the Regional Maintenance Director during a tour of the facility from 2:00 p.m. to 4:30 p.m. on 03/18/24, one of two corridor doors serving as the entrance to the Activity Room in the basement was not equipped with a latching mechanism and a self-closing or automatic closing device. The door was warped and was ajar from the door frame. The other entrance door to the Activity Room was held in the fully open position	K 0321	**K 321** Hazardous Areas – Enclosure CFR(s): NFPA 101 No residents were affected by this deficient practice. The Maintenance Director has positively secured one of two doors serving as the entrance to the Activity Room in the basement. The door mentioned is NO LONGER being used as a door. This deficient practice could affect over 5 residents, staff and visitors in the basement. No residents were affected by this deficient practice. In addition, the Maintenance Director installed the self-closing device on the door to the “Employee Only” room in the basement. It has been tested and closes properly.	04/18/2024

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	with a wall mounted magnetic holding device set to release the self closing door to close with fire alarm system activation. The Activity Room had several areas which were open to the room which was being used to stockpile combustible supplies such as Christmas decorations and Activity Room supplies. Because the room was over 50 square feet in size, each corridor door serving as the entrance to the room must be separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing. Based on interview at the time of the observations, the Interim Executive Director stated residents have customary access to the Activity Room in the basement. In addition, the self closing device on the corridor door to the "Employee Only" room in the basement was detached. The room was in excess of 50 square feet in size and was used to store furniture and combustible boxes and supplies. Based on interview at the time of the observations, the Interim Executive Director and the Regional Maintenance Director agreed the aforementioned two hazardous areas were not separated from other spaces with smoke resistant partitions and doors. These findings were reviewed with the Interim Executive Director and the Regional Maintenance Director during the exit conference. 3.1-19(b)		This deficient practice could affect over 5 residents, staff and visitors in the basement. The Maintenance Director has been educated on K321 Enclosures. The Director of Maintenance will perform daily reviews(M-F) for 4 weeks, Weekly reviews for 2 months, monthly reviews for 3 months for a total of 6 months. This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. **Compliance Date** 4-18-24	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:			

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	* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			
	1. Based on observation and interview, the facility failed to ensure the cook top for 1 of 1 stoves/ovens in the therapy room was shut off at the switch when not in use. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop	K 0324	**K 324** Cooking Facilities CFR(s): NFPA 101 The Director of Maintenance has put a disconnect on the stove and put baffles above the cooktop into proper placement. The missing stove disconnect could have affected residents, staff and visitors in the therapy room. This deficient practice with the baffles were not in the resident care area but could affect staff in the kitchen. The Director of Maintenance has been educated by the Executive Director on K324. The Director of Maintenance will perform daily reviews of the baffles (M-F) for 4 weeks, Weekly reviews for 2 months, monthly reviews for 3 months for a total of 6 months.	04/18/2024

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	or range whenever the kitchen is not under staff supervision. This deficient practice could affect residents, staff and visitors in the therapy room. Findings include: Based on observation during a tour of the facility with the Regional Maintenance Director and the Interim Executive Director on 03/18/2024 between 2:00 PM and 4:30 PM, there was a cooktop stove/oven in the therapy room. The stove/oven disconnect was unable to be located. Based on interview at the time of observation, the Regional Maintenance Director agreed the stove/oven disconnect was unable to be located. This finding was reviewed with the Interim Executive Director and Regional Maintenance Director at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to install the kitchen range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 edition, Section 6.1.1 states listed grease filters, listed baffles, or other listed grease removal devices for use with commercial cooking equipment shall be provided. Section 6.2.3 states grease filters shall be arranged so that all exhaust air passes through the grease filters. This deficient practice could affect staff in the kitchen. Findings include:		This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. **Compliance Date** 4-18-24	

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	Based on observation during a tour of the facility with the Interim Executive Director and the Regional Maintenance Director on 03/18/2024 between 2:00 PM and 4:30 PM, 4 of 5 baffles above the cooktop was out of place. Based on interview at the time of observation, the Regional Maintenance Director agreed the baffles were out of place. This finding was reviewed with the Regional Maintenance Director and Interim Executive Director at the exit conference. 3.1-19(b)			
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). Based on observation, interview and record review; the facility failed to ensure materials used as an interior finish on the first floor had a flame spread rating of Class A or Class B. LSC 101 10.2.3.4 states products required to be tested in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, shall be grouped in the following classes in accordance with their flame spread and smoke development.	K 0331	**K 331** Interior Wall and Ceiling Finish CFR(s): NFPA 101 No residents were affected by this deficient practice. The Maintenance Director has received the documentation regarding flame spread rating for wall finishes and they are available for review. The deficient practice could affect	04/18/2024

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	(a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect up to 15 residents, staff, and visitors while in the same smoke compartments. Findings include: Based on record review, with the Regional Maintenance Director and Interim Executive Director on 03/18/2024 between 11:30 AM and 2:00 PM, no documentation regarding flame spread rating for wall finishes was available. Based on interview at the time of record review, the Regional Maintenance Director stated he was not aware of where the flame spread documentation for the wall coverings was located. Based on observation on 03/18/2024 between 2:00 PM and 4:30 PM with the Regional Maintenance Director and Interim Executive Director, wall paper was observed on the corridor walls of the first floor. This finding was reviewed with Regional Maintenance Director and Interim Executive Director during the exit conference.		up to 15 residents, staff, and visitors while in the same smoke compartments. The Maintenance Director has been educated on K331 Compliance date 4/18/2024	

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K 0353 SS=E Bldg. 01	3.1-19(b) NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 4 ceiling smoke barriers, 1 of l areas near room 304, 1 of 1 marketing closets in the Beauty Salon, and 1 of 1 areas between the kitchen storage and dish room. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect over 5 residents, staff and visitors in the vicinity	K 0353	**K 353** Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 The Director of Maintenance have properly fixed Ceiling penetrations. This deficient practice could affect over 5 residents, staff and visitors in the vicinity of Employee Only room in the basement. The Director of Maintenance has been educated by the Executive Director on K353. The Director of Maintenance will perform daily reviews(M-F) for 4 weeks, Weekly reviews for 2 months, monthly reviews for 3	04/18/2024

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	of Employee Only room in the basement. Findings include: Based on observations with the Interim Executive Director and the Regional Maintenance Director during a tour of the facility from 2:00 p.m. to 4:30 p.m. on 03/18/24, one suspended ceiling tile was missing in the suspended ceiling tile grid in the basement "Employee Only" room which contained the TV equipment for the facility. Based on interview at the time of the observations, the Regional Maintenance Director agreed the missing ceiling tile in the ceiling tile grid did not maintain ceiling construction. A penetration was located in the ceiling in between room 304 and the exit stairwell of approximately 1/4 inch which had something combustible filling the penetration. Based on interview at the time of observation, the Regional Maintenance Director stated the building's Maintenance Director had been replacing lighting and may not have had time to put in a new light fixture. In the marketing closet in the beauty salon in the basement, a ceiling penetration of approximately 1.5 ft by 1.5 ft was located. Based on interview at the time of observation, the Regional Maintenance Director agreed the penetration was present and provided the measurements. The area outside of the kitchen storage and the dish room was observed to have a penetration of 1 ft by 4 ft in the ceiling. Based on interview at the time of observation, the Regional Maintenance Director agreed there was a penetration and provided the measurements. These findings were reviewed with the Interim Executive Director and the Regional Maintenance Director during the exit conference. 3.1-19(b)		months for a total of 6 months. This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. **Compliance Date** 4-18-24	

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	2. Based on observation and interview, the facility failed to ensure clearance of at least 18 inches was maintained below the level of the sprinkler deflectors in 1 of 1 kitchen storage rooms. NFPA 25, 2011 Edition, Section 5.2.1.2 states the minimum clearance required by the installation standard shall be maintained below all sprinkler deflectors. Further NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 edition, Section 8.6.5.2.2 states the distance from sprinklers to privacy curtains in light hazard occupancies shall be in accordance with Table 8.6.5.2.2 and Figure 8.6.5.2.2. Table 8.6.5.2.2 states suspended horizontal obstructions more than thirty inches in length shall maintain a minimum vertical distance below the sprinkler deflector of 18 inches. Section 8.6.5.2.2.1 states, in light hazard occupancies, privacy curtains shall not be considered obstructions where all of the following are met: (1) The curtains are supported by fabric mesh on ceiling track. (2) Openings in the mesh are equal to 70 percent or greater. (3) The mesh extends a minimum of 22 inches down from the ceiling. In addition, Section 8.6.6.1 states the clearance between the deflector and the top of storage shall be 18 inches or greater. This deficient practice could affect staff. Finding includes: Based on observation during a tour of the facility on 03/18/2024 from 2:00 PM to 4:30 PM with the Regional Maintenance Director and the Interim Executive Director, there were kitchen storage items being stored on shelves less than 18 inches from the sprinkler deflectors. Based on interview at the time of observation, the Regional			

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	Maintenance Director agreed the storage was less than 18 inches from the sprinkler deflectors. This finding was reviewed with the Interim Executive Director and Regional Maintenance Director at the time of the exit conference. 3.1-19(b)			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 1. Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the basement medical record rooms were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice was not in a resident care area but could affect all staff in the medical record room. Findings include: Based on observations during a tour of the facility with the Regional Maintenance Director and Interim Executive Director on 03/18/2024 between 2:00 PM and 4:30 PM, the ABC portable fire extinguisher located in the basement medical record room was sitting on a table. Based on	K 0355	**K 355** Portable Fire Extinguishers CFR(s): NFPA 101 **Immediate Intervention** The Director of Maintenance has mounted the previously unsecured fire extinguisher to the wall with a hanger. This deficient practice was not in the resident care area but could affect staff in the medical records room. The Director of Maintenance has been educated by the Executive Director on K355 All extinguishers must be installed and secured per NFPA standards. The Director of Maintenance will perform monthly audit check and signing off on extinguisher tag. Results of these reviews will be presented by the Executive Director to the QAPI committee for	04/18/2024

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	interview at the time of observation, the Regional Maintenance Director acknowledged the extinguisher was sitting on the table not mounted. This finding was reviewed with the Interim Executive Director and Regional Maintenance Director at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to inspect 1 of 1 portable fire extinguishers in the lobby, 1 of 1 portable fire extinguishers in the therapy room, and 1 of 1 fire extinguishers in the basement medical record room each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using pushto-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person		further recommendations. **Compliance Date** 4-18-24	

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	performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect up to 24 residents, as well as staff and visitors. Findings include: Based on an observations during a tour of the facility on 03/18/2024 between 2:00 PM and 4:30 PM with the Regional Maintenance Director and Interim Executive Director, the fire extinguishers in the lobby, therapy room and medical room were not signed they were inspected in February 2024. Based on interview at the time of observations, the Regional Maintenance Director agreed the fire extinguishers in the aforementioned locations had not been signed they were inspected in February 2024. This finding was reviewed with the Interim Executive Director and Regional Maintenance Director at the exit conference. 3.1-19(b)			
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			

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	and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 1 of 1 therapy rooms were separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). 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 over 5 residents, staff and visitors in the vicinity of the Therapy Room on the first floor. Findings include: Based on observations with the Interim Executive Director and the Regional Maintenance Director during a tour of the facility from 2:00 p.m. to 4:30 p.m. on 03/18/24, the corridor door to the Therapy Room on the first floor at the south end of the building was equipped with thumb twist latching hardware on the room side of the door which required a key to lock or unlock the door on the corridor side of the door. Based on interview at the time of the observations, the Interim Executive Director and the Regional Maintenance Director stated the door is always unlocked and agreed the corridor door to the aforementioned Therapy Room was not equipped with a positive latching device. These findings were reviewed with the Interim	K 0361	**K 361** Corridors - Areas Open to Corridor CFR(s): NFPA 101 Applied for waiver. No residents were affected by this deficient practice. This door can still shut, preventing the passage of smoke and fire. The door will remain unlocked/unlatched to allow egress in an emergency until the door company can install a positive latching device. Central Indiana Hardware has been contacted to add crash bar and latching equipment. This deficient practice could affect over 5 residents, staff and visitors in the vicinity of the Therapy Room on the first floor. The Maintenance Director has been educated on K361. The Director of Maintenance will perform daily reviews(M-F) for 4 weeks, Weekly reviews for 2 months, monthly reviews for 3 months for a total of 6 months. This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. **Compliance Date** 12-01-24	12/01/2024

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	155061	A. BUILDING 01 B. WING	03/18/2024

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	Executive Director and the Regional Maintenance Director during the exit conference. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire			

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	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 2 of 14 resident sleeping rooms on the first floor, 1 of 1 medical record rooms in the basement, and 1 of 1 basement mechanical rooms near the main elevator were unable to latch in the door frame. This deficient practice could affect up to 4 residents, staff, and visitors. Findings include: Based on observations during a tour of the facility with the Regional Maintenance Director and Interim Executive Director on 03/18/2024 between 2:00 PM and 4:30 PM, Rooms 103 and 108 were unable to latch. Based on interview at the time of observation, the Regional Maintenance Director agreed the doors would not latch. The Regional Maintenance Director removed the wreath hanging on the door to Room 103 and then the door was able to latch. The door to the medical record room in the basement had a self-closer but was unable to latch into the frame. The Regional Maintenance Director agreed the door was not able to latch. The basement mechanical room near the main elevator was also unable to latch. The Regional Maintenance Director agreed the door was not able to latch. This finding was reviewed with the Regional Maintenance Director and Interim Executive Director at the exit conference.	K 0363	**K 363** Corridor - Doors CFR(s): NFPA 101 The Director of Maintenance fixed the door latches. This deficient practice could affect up to 4 residents, staff and visitors. The Director of Maintenance has been educated by the Executive Director on K363 All doors with closers shall close and latch on their own power. The Director of Maintenance will perform room 108 and Mechanical room in basement daily reviews(M-F) for 4 weeks, Weekly reviews for 2 months, monthly reviews for 3 months for a total of 6 months. This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. Compliance date 4/18/24	04/18/2024

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K 0511 SS=B Bldg. 01	3.1-19(b) NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 cover plates in the maintenance office and 1 of 1 cover plates in the electrical panel room near the generator control room was protected. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect staff. Findings include: Based on observation during a tour of the facility with the Regional Maintenance Director and Interim Executive Director on 03/18/2024 between 2:00 PM and 4:30 PM, the receptacle covers in the maintenance office and the electrical panel room near the generator control room were not present. Based on interview at the time of observation, the Regional Maintenance Director agreed the coverplates were missing from the aforementioned locations. This finding was reviewed with the Interim Executive Director and Regional Maintenance Director at the exit conference.	K 0511	**K 511** Utilities - Gas and Electric CFR(s): NFPA 101 No residents were affected by this deficient practice. The Maintenance Director installed receptacle covers in the maintenance office and the electrical panel room. This deficient practice could affect staff. The Maintenance Director has been educated on K511 The Director of Maintenance will perform daily reviews(M-F) for 4 weeks, Weekly reviews for 2 months, monthly reviews for 3 months for a total of 6 months. This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. **Compliance Date** 4-18-24	04/18/2024

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	3.1-19(b)			
K 0541 SS=E Bldg. 01	NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chu Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 Based on observation and interview, the facility failed to maintain 1 of 1 laundry chutes in accordance with NFPA 82, Standard on Incinerators and Waste and Linen Handling Systems and Equipment. LSC 9.5.2 requires laundry chutes shall be installed and maintained per NFPA 82, 2009 Edition. NFPA 82, Section 5.2.3.3.1.1 and Section 5.2.3.3.2.1 requires all chute	K 0541	**K 541** Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 The Director of Maintenance repaired the latch on the door immediately. This deficient practice could affect up to 10 residents, staff, and	04/18/2024

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	loading doors shall be provided with a self-closing, positive latching frame and gasketed door assembly. This deficient practice could affect over 10 residents, staff and visitors on the third floor. Findings include: Based on observations with the Interim Executive Director and the Regional Maintenance Director during a tour of the facility from 2:00 p.m. to 4:30 p.m. on 03/18/24, the latching mechanism for the soiled linen chute door in the third floor stairwell by Room 311 failed to work properly which caused the chute door to not self-close and latch into the chute's door frame when tested to close multiple times. Based on interview at the time of observation, the Regional Maintenance Director agreed the aforementioned laundry chute door on the third floor failed to self-close and latch into the chute's door frame. These findings were reviewed with the Interim Executive Director and the Regional Maintenance Director during the exit conference. 3.1-19(b)		visitors on the third floor. The Director of Maintenance has been educated by the Executive Director on K541. All chute loading doors shall be provided with a self-closing, positive latch frame and gasketed door assembly to prevent smoke and fire from spreading. The Director of Maintenance will perform daily reviews(M-F) for 4 weeks, Weekly reviews for 2 months, monthly reviews for 3 months for a total of 6 months. This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. **Compliance Date** 4/18/24	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded			

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	announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills for 1 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review of the fire drill reports with the Regional Maintenance Director and Interim Executive Director on 03/18/2024 between 11:30 AM and 2:00 PM, there was no documentation available for review for a third quarter second shift fire drill. Based on interview at the time of record review, the Regional Maintenance Director agreed there was no documentation for the third quarter second shift fire drill that he was aware of. This finding was reviewed with the Regional Maintenance Director and Interim Executive Director at the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	**K 712** Fire Drills CFR(s): NFPA 101 No residents were affected by this deficient practice. The Maintenance Director now preschedules fire drills and are done timely. This deficient practice could affect all residents and staff. The Maintenance Director has been educated on K712 which requires fire drills to be conducted quarterly on each shift under varied conditions. The Director of Maintenance now preschedules drills for the year in Tels. **Compliance Date** 4-18-24	04/18/2024
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled			

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	linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility failed to ensure unattended trash receptacles stored in 1 of 8 means of egress were stored in a room protected as a hazardous area in accordance with Section 19.7.5.7. This deficient practice could affect over 5 residents, staff and visitors in the vicinity of basement Laundry room. Findings include: Based on observations with the Interim Executive Director and the Regional Maintenance Director during a tour of the facility from 2:00 p.m. to 4:30 p.m. on 03/18/24, one large unattended trash receptacle was stored in the corridor outside the basement Laundry room. The trash receptacle was in excess of 64 gallon capacity and was partially filled with trash at the bottom of the receptacle. Based on interview at the time of the observations, the Interim Executive Director stated residents have customary access to the Activity Room in the basement. The Regional Maintenance Director asked Laundry staff if the receptacle is stored in the corridor who stated the trash receptacle is normally stored in the corridor and agreed the aforementioned receptacle was not being stored in a room protected as a hazardous area when unattended.	K 0754	**K 754** Soiled Linen and Trash Containers CFR(s): NFPA 10 No residents were affected by this deficient practice. The Maintenance Director removed the trash receptacle. This deficient practice could affect over 5 residents, staff and visitors in the vicinity of the basement laundry room. The Maintenance Director has been educated on K754 that mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. The Director of Maintenance will perform daily reviews(M-F) for 4 weeks, Weekly reviews for 2 months, monthly reviews for 3 months for a total of 6 months. This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be	04/18/2024

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	These findings were reviewed with the Interim Executive Director and the Regional Maintenance Director during the exit conference. 3.1-19(b)		presented by the Executive Director to the QAPI committee for further recommendations. **Compliance Date** 4-18-24	
K 0911 SS=F Bldg. 01	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems 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. Chapter 6 (NFPA 99) 1. Based on observation and interview, the facility failed to ensure all circuits on the life safety branch supply power to circuits essential for life safety in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.2.2.3.2 states the life safety branch shall supply power for lighting, receptacles, and equipment as follows: (1) Illumination of means of egress in accordance with NFPA 101, Life Safety Code. (2) Exit signs and exit directional signs in accordance with NFPA 101, Life Safety Code. (3) Hospital communication systems, where used for issuing instruction during emergency conditions. (4) Generator set location as follows: (a) Task illumination (b) Battery charger for emergency battery-powered lighting unit(s) (c) Select receptacles at the generator set location and essential electrical system transfer switch locations	K 0911	**K 911** Electrical Systems - Other CFR(s): NFPA 101 Applied for waiver. The facility no longer has a vent unit, nor provides care to residents with vents, thus ending the critical branch. The facility will find an electrician that understands the Life Safety branch requirements and have any mixed branches separated. This deficient practice could affect 7 residents. The Maintenance Director has been educated on K911. The Director of Maintenance will perform daily reviews(M-F) for 4 weeks, Weekly reviews for 2 months, monthly reviews for 3 months for a total of 6 months. This audit will be placed into the	12/01/2024

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	(5) Elevator cab lighting, control, communications, and signaling systems. (6) Electrically powered doors used for building egress. (7) Fire alarms and auxiliary functions of fire alarm combination systems complying with NFPA 72, National Fire Alarm and Signaling Code. Section 6.4.2.2.3 states alarm and alerting systems (other than fire alarm systems) shall be connected to the life safety branch or the critical branch. Section 6.4.2.2.3.4 states loads dedicated to a specific generator, including the fuel transfer pump(s), ventilation fans, electrically operated louvers, controls, cooling systems, and other generator accessories essential for generator operation, shall be connected to the life safety branch or the output terminals of the generator with over-current protective devices. Section 6.4.2.2.3.5 states no functions other than those in 6.4.2.2.3.2, 6.4.2.2.3.3, and 6.4.2.2.3.4 shall be connected to the life safety branch, except as specifically permitted in 6.4.2.2.3. Section 6.4.2.2.6.1 states the life safety branch shall be kept independent of all other wiring and equipment. This deficient practice could affect 7 residents. Findings include: Based on observations with the Interim Executive Director and the Regional Maintenance Director during a tour of the facility from 2:00 p.m. to 4:30 p.m. on 03/18/24, vent unit beds are located in Rooms 101, 102, 103, 104, 105, 106 and 107 on the first floor for a total of 8 vent unit bed locations. It could not be assured all life safety branch circuits were separated from non-life safety branch circuits. The facility has one diesel fired emergency generator rated at 100 kW. The facility has two transfer switches located in the "Electrical		Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. **Compliance Date** 12-01-24	

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	Panel Generator Control" room in the basement near the Laundry room. Six electrical panels in the electrical room were connected to the emergency generator and to the normal source. The electrical panel identified as "Isolated Panel for Emergency Generator" had circuits identified as "Call Lights" mixed with the circuits for the fire alarm system, the emergency generator and egress lighting. The electrical panel identified as "Panel W" had "Dryer" and "AC Laundry" circuits mixed with circuits for the emergency generator and the emergency generator block heater. Two electrical panels were for PTAC circuits. The remaining two electrical panels were for newly installed critical branch circuits for newly installed electrical receptacles installed in Room 101, 102, 103, 104, 105, 106 and 107. One of the "Critical Branch" circuit panels had circuits labeled "Isolated Panel for Generator" which would indicate this subpanel is on the "Critical Branch" panel. Based on interview at the time of the observations, the Regional Maintenance Director provided the electrical contractor's "Work Performed" documentation dated 04/25/23 which stated "alterations to the basement electrical room" but did not indicate the alterations fully complied with NFPA 99 requirements. The Regional Maintenance Director agreed it could not be ensured all life safety branch circuits were separated from non-life safety branch circuits. These findings were reviewed with the Interim Executive Director and the Regional Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure all circuits on the critical branch supply power to critical branch functions			

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	related to patient care in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.2.2.4.2 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states the critical branch shall supply power for task illumination, fixed equipment, select receptacles, and select power circuits serving the following areas and functions related to patient care: (1) Critical care areas that utilize anesthetizing gases, task illumination, select receptacles, and fixed equipment (2) Isolated power systems in special environments (3) Task illumination and select receptacles in the following: (a) Patient care rooms, including infant nurseries, selected acute nursing areas, psychiatric bed areas (omit receptacles), and ward treatment rooms (b) Medication preparation areas (c) Pharmacy dispensing areas (d) Nurses' stations (unless adequately lighted by corridor luminaries) (4) Additional specialized patient care task illumination and receptacles, where needed (5) Nurse call systems (6) Blood, bone, and tissue banks (7) Telephone equipment rooms and closets (8) Task illumination, select receptacles, and select power circuits for the following areas: (a) General care beds with at least one duplex receptacle per patient bedroom, and task illumination as required by the governing body of the health care facility (b) Angiographic labs (c) Cardiac cathertization labs (d) Coronary care units (e) Hemodialysis rooms or areas			

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ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

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	(f) Emergency room treatment areas (select) (g) Human physiology labs (h) Intensive care units (i) Postoperative recovery rooms (select) (9) Additional task illumination, receptacles, and select power circuits needed for effective facility operation, including single-phase fractional horsepower motors, which are permitted to be connected to the critical branch. Section 6.4.2.2.6.1 states the critical branch shall be kept independent of all other wiring and equipment. This deficient practice could affect 8 residents. Findings include: Based on observations with the Interim Executive Director and the Regional Director of Facilities during a tour of the facility from 2:00 p.m. to 4:30 p.m. on 03/18/24, vent unit beds are located on the first floor in Rooms 101, 102, 103, 104, 105, 106 and 107 for a total of 8 vent unit bed locations. It could not be assured all critical branch circuits were separated from non-critical branch circuits. The facility has one diesel fired emergency generator rated at 100 kW. The facility has two transfer switches located in the "Electrical Panel Generator Control" room in the basement near the Laundry room. Six electrical panels in the electrical room were connected to the emergency generator and to the normal source. The electrical panel identified as "Isolated Panel for Emergency Generator" had circuits identified as "Call Lights" mixed with the circuits for the fire alarm system, the emergency generator and egress lighting. The electrical panel identified as "Panel W" had "Dryer" and "AC Laundry" circuits mixed with circuits for the emergency generator and the emergency generator block heater. Two electrical panels were for PTAC circuits. The remaining two			

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	electrical panels were for newly installed critical branch circuits for newly installed electrical receptacles installed in Room 101, 102, 103, 104, 105, 106 and 107. One of the "Critical Branch" circuit panels had circuits labeled "Isolated Panel for Generator" which would indicate this subpanel is on the "Critical Branch" panel. Based on interview at the time of the observations, the Regional Director of Facilities provided the electrical contractor's "Work Performed" documentation dated 04/25/23 which stated "alterations to the basement electrical room" but did not indicate the alterations fully complied with NFPA 99 requirements. The Regional Director of Facilities agreed it could not be ensured all critical branch circuits were separated from non-critical branch circuits. These findings were reviewed with the Interim Executive Director and the Regional Director of Facilities during the exit conference. 3.1-19(b)			
K 0920 SS=E 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			

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	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 power strips in room 313 was not used as a substitute for fixed wiring and 1 of 2 power strips in room 215. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed, and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors	K 0920	**K 920** Electrical Equipment - Power Cords and Extension CFR(s): NFPA 101 No residents were affected by this deficient practice. The Maintenance Director removed the power strips from resident rooms. This deficient practice could affect 3 residents, visitors or staff. The Maintenance Director has been educated on K920 powerstrips. The Director of Maintenance will perform daily reviews(M-F) for 4 weeks, Weekly reviews for 2 months, monthly reviews for 3 months for a total of 6 months.. This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. **Compliance Date** 4-18-24	04/18/2024

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	in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect 3 residents, staff, and visitors. Findings include: Based on observation during a tour of the facility with the Regional Maintenance Director and the Interim Executive Director on 03/18/2024 between 2:00 PM and 4:30 PM, a mini fridge was plugged into a power strip and not directly into the wall in room 313. Based on interview at the time of observation, the Regional Maintenance Director agreed the mini fridge was plugged into a power strip. In Room 215, a refrigerator, cell phone charging cable, and a TV were plugged into a power strip within 5 feet of the resident bed nearest the window. Based on interview at the time of observation, the Regional Maintenance Director agreed the TV, charging cord, and refridgerator were plugged into a power strip. These findings were reviewed with the Interim Executive Director and the Regional Maintenance Director.. 3.1-19(b)			
K 0923 SS=D 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			

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	enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	1. Based on observation and interview, the facility failed to ensure 1 of 3 indoor oxygen storage areas was in accordance with NFPA 99, Health Care Facilities Code. 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	K 0923	**K 923** Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101 No residents were affected by this deficient practice. The	04/18/2024

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	meters (3000 cubic feet), at STP shall comply with the requirements of 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.1 states storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. In addition, Section 11.3.2.7 states smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the "Electrical Room" by Room 303 on the third floor. Findings include: Based on observations with the Interim Executive Director and the Regional Maintenance Director during a tour of the facility from 2:00 p.m. to 4:30 p.m. on 03/18/24, one liquid oxygen container was stored within one foot of a wall mounted electrical panel in the "Electrical Room" by Room 303 on the third floor. The liquid oxygen container was not stored within the working space in front of or below the electrical panel. The scale for the container indicated it was one half full of oxygen. Based on interview at the time of the observations, the Regional Maintenance Director agreed the liquid oxygen container was stored in a room along with other sources of ignition. These findings were reviewed with the Interim Executive Director and the Regional Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 outdoor oxygen storage		Maintenance Director removed the liquid oxygen container that was stored within one foot of a wall mounted electrical panel. This deficient practice could affect over 10 residents, staff or visitors in the vicinity of the “Electrical Room” by Room 303 on the third floor. The Maintenance Director has been educated on K923 oxygen storage locations. **Compliance Date** 4-18-24	

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	areas was in accordance with NFPA 99, Health Care Facilities Code. 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), at STP shall comply with the requirements of 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.1 states storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. Section 11.3.2.3 states oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) Minimum distance of 6.1 m (20 ft) (2) Minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1/2 hour. In addition, Section 11.3.2.7 states smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations. This deficient practice could affect 1 staff and visitors in the vicinity of the outdoor oxygen storage area on the west side of the property. Findings include: Based on observations with the Interim Executive Director and the Regional Director of Facilities during a tour of the facility from 2:00 p.m. to 4:30 p.m. on 03/18/24, combustible boxes and furniture were stored up against one liquid oxygen			

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	container located in the outdoor oxygen storage area which was detached from the building on the west side of the property. The detached oxygen storage area was not sprinklered. Based on interview at the time of the observations, the Interim Executive Director and the Regional Director of Facilities stated the facility no longer utilizes this outdoor oxygen storage area but agreed combustible materials were stored within 20 feet of the liquid oxygen container. These findings were reviewed with the Interim Executive Director and the Regional Director of Facilities during the exit conference. 3.1-19(b)			
K 0930 SS=A Bldg. 01	NFPA 101 Gas Equipment - Liguid Oxygen Equipment Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) Based on observation and interview, the facility failed to protect 1 of over 40 resident sleeping rooms from the use of liquid oxygen containers stored in a patient bed location or patient care room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.7.4 states the maximum total quantity of liquid oxygen permitted in storage and in use in a patient bed location or patient care room shall be 120 L (31.6 gallons), provided that the patient bed location or patient care room, or both, are separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour in accordance with the adopted building code. LSC Section 7.2.4.3.10 requires all fire door	K 0930	K930 Gas Equipment - Liguid Oxygen Equipment CFR(s): NFPA 101 No residents were affected by this deficient practice. The Maintenance Director removed the liquid oxygen from the patient room. The deficient practice could affect one resident, staff and visitors. The Maintenance Director has been educated on K930 Gas Equipment - Liquid Oxygen. **Compliance Date**	04/18/2024

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	assemblies in horizontal exits shall be self-closing or automatic-closing. This deficient practice could affect one resident, staff and visitors. Findings include: Based on observations with the Interim Executive Director and the Regional Maintenance Director during a tour of the facility from 2:00 p.m. to 4:30 p.m. on 03/18/24, one liquid oxygen container was stored in resident sleeping Room 107 and was available for use for the vent unit bed location in resident sleeping Room 107. One resident was observed in the vent unit bed location at the time of the observations. The liquid oxygen container was not currently being used by the resident at the time of the observations. Room 107 was not separated from the remainder of the facility by fire barriers having a minimum fire resistance rating of 1 hour because the corridor door to the room was not self-closing or automatic closing and was not equipped with a fire resistance rating label. Based on interview at the time of the observations, the Regional Maintenance Director agreed one liquid oxygen container was stored in resident sleeping Room 107 and the room was not maintained with a minimum fire resistance rating of 1 hour. These findings were reviewed with the Interim Executive Director and the Regional Maintenance Director during the exit conference. 3.1-19(b)		4-18-24	