STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155160	A. BUILDING -- B. WING	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STONEBROOKE REHABILITATION CENTER	990 N 16TH ST NEW CASTLE, IN 47362

(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: 02/16/23 Facility Number: 000080 Provider Number: 155160 AIM Number: 100289330 At this Emergency Preparedness survey, Stonebrooke Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 117 certified beds. At the time of the survey, the census was 67. Quality Review completed on 02/20/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/16/23 Facility Number: 000080 Provider Number: 155160 AIM Number: 100289330 At this Life Safety Code survey, Stonebrooke	K 0000	Stonebrooke Rehabilitation Center respectfully requests to be considered for Paper Compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Eileen Thomas HFA	Executive Director	03/03/2023

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	Rehabilitation Center 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 two-story facility was determined to be of Type II (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection on all levels including the corridors, spaces open to the corridors and hard-wired smoke detectors in resident room 100, 101, 102, 103, 104, 105, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135 and 136. The facility has battery operated smoke detectors in resident rooms 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 238, 239, 240, 242, 243, 244, 245, 246, 247, 248, 249, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119. The facility has a capacity of 117 and had a census of 67 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had two detached wooden storage sheds and one detached metal storage shed which were not sprinklered. Quality Review completed on 02/20/23			
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			

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	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, the facility failed to meet the clear width requirement for 1 of 8 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by LSC 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in LSC 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with LSC 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with LSC 19.3.5.8 This deficient practice could affect all residents, staff and visitors exiting the Second Floor Managers Hall corridor.	K 0232	K-232 SS=E · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **The furniture that was on the 2nd floor Managers Hall, has been moved.** · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. **An audit was conducted of all other exit corridors, no other areas were identified.** · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **An inservice for all staff will be conducted to ensure that the requirements of K-232 are understood and met on-going. Additionally, the Maintenance Director or Executive Director will ensure all contracted staff are aware of the requirements to maintain a clear means of egress.** · how the corrective action(s)	04/03/2023

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	Findings: Based on observations and interview with the Maintenance Director and Administrator during a tour of the facility from 11:10 a.m. to 1:55 p.m. on 02/16/23, The Managers Hall Corridor on the second floor contained tables, chairs, boxes and upholstered furniture which extended the complete length of the corridor. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)		will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **The Maintenance Director or designee will conduct an audit weekly x 4 weeks monthly x 3 months, and quarterly until the QAPI committee determines that substantial compliance has been accomplished. If 95% compliance is not achieved an action plan will be implemented**.	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of over 6 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect 12 residents and staff using the Moving Forward Hall Exit. Findings include:	K 0271	· what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **The concrete sidewalk outside the Moving Forward exit will be repaired.** · how other residents having the potential to be affected by the	04/03/2023

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	Based on observations and interview with the Maintenance Director and Administrator during a tour of the facility from 11:10 a.m. to 1:55 p.m. on 02/16/23, the exit discharge from the Moving Forward Hall Exit, had large cracks in the concrete and was uneven where the seams joined. At the time of observation, the Administrator acknowledged that the walkway was in need of repair to have a complete level walking surface that was free of obstructions leading to the common way. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)		same deficient practice will be identified and what corrective action(s) will be taken. **An audit of all exterior sidewalks was conducted, other identified areas will be repaired.** · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **The Maintenance Director or designee will at least quarterly as part of his QAPI report include the conditions of the sidewalks, and immediately report any concerns to Executive Director.** · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **The Maintenance Director or designee will at least quarterly as part of his QAPI report include the conditions of the sidewalks, reporting to the QAPI committee any repair needs.**	
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			

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	automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of 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 6 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 15 residents, as well as staff and visitors. Findings include: Based on observations and interview with the Maintenance Director and Administrator during a	K 0321	· what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **Rooms 245, 246, 247, 248, 249 and 250 and Cherrywood Dining Room have been designated as short term storage and equipped with self-closure devices, or excessive storage items have**	04/03/2023

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	tour of the facility from 11:10 a.m. to 1:55 p.m. on 02/16/23, the following was noted: A) Room 240, greater than 50 square feet, contained a number of combustible items, such as, paper, plastic, and more than 8 bed mattresses. The corridor door to this room was not equipped with a self-closing device. B) Room 243, greater than 50 square feet, contained numerous tables, chairs and room furniture which was being stored inside the room. The room not equipped with a self-closing device or self-closing hinges. C) Room 247, greater than 50 square feet, contained 4 large boxes, pallets and room air conditioner unit which were being stored in the room. The room not equipped with a self-closing device or self-closing hinges. D) Room 243, greater than 50 square feet, contained a pallet with boxes of uninstalled flooring material and tables which were being stored in the room. The room not equipped with a self-closing device or self-closing hinges. E) Room 244, greater than 50 square feet, contained 4 PPE carts and 3 beds which were being stored in the room. The room not equipped with a self-closing device or self-closing hinges. F) The Cherrywood dining area, greater than 50 square feet, contained 18 boxes, 15 1 gallon cans of paint and 7 five gallon paint containers all of which were being stored in the room. The room not equipped with a self-closing device or self-closing hinges. G) The Oxygen Room door failed to self-close and		**been removed.** · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. **An audit was conducted, and no other areas were identified to be affected by the same deficient practice.** · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **Rooms that have stored items will be equipped with self-closing device by the maintenance director or designee.** · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **The Maintenance Director will inspect all rooms with self-closing devices for proper function weekly x 4 weeks monthly x 3 months, and quarterly until the QAPI committee determines that substantial compliance has been accomplished. If 95% compliance is not achieved an action plan will be implemented**.	

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	latch into the door frame. The latching mechanism was covered with tape preventing it from latching securely. The Maintenance Director stated that the staff likely did this because the electronic keypad used to access the room was missing so many numbers that it was not usable, and that it would need to be replaced. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)			
K 0352 SS=F Bldg. 01	NFPA 101 Sprinkler System - Supervisory Signals Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 Based on observation and interview, the facility failed to maintain automatic sprinkler systems in accordance with LSC 9.7. LSC 19.3.5.1 states buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. LSC 9.7.2.1 states where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and a distinctive supervisory signal shall be provided to indicate a	K 0352	· what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **The PIV has been connected to the fire panel to be electronically supervised.** · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.	04/03/2023

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	condition that would impair the satisfactory operation of the sprinkler system. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations and interview with the Maintenance Director during a tour of the facility from 11:10 a.m. to 1:55 p.m. on 02/16/23, the Post Indicator Valve (PIV) located outside the facility near the FDC connection was not electrically supervised. Based on interview at the time of the observations, the Maintenance Director agreed the PIV was not electrically supervised. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)		**All residents had the potential to be affected. The PIV has been connected to the fire panel.** · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **The connection will be monitored thorough the on-going inspections of the fire panel.** · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **The connection will be monitored thorough the on-going inspections of the fire panel.**	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____			

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	b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observations and interview with the Maintenance Director during a tour of the facility from 11:10 a.m. to 1:55 p.m. on 02/16/23, there were two spare sprinkler cabinets in the riser room closet, one of which included 14 spare sprinklers; 12 of which were not in their own protected slot. They were stored loose in the cabinet and not secured in holders. Based on interview at the time of the observation, the Maintenance Director	K 0353	· what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **The facility has a spare type of each sprinkler, securely stored in an approved cabinet. The sprinkler head located in the laundry has been properly cleaned. Ceiling tiles in the therapy gym have been properly placed to allow the sprinkler system to function properly.** · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. **All residents had the potential to be affected. Spare sprinkler heads are now properly secured and stored. All sprinkler heads were inspected to ensure they are free of load or foreign material. All ceiling tiles were inspected for proper placement, to ensure tiles work to properly trap hot air or gases around the sprinkler system.**	04/03/2023

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	agreed the spare sprinkler cabinet had spare sprinklers not in protected slots. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler heads in the laundry area were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect 3 laundry staff. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:10 a.m. to 1:55 p.m. on 02/16/23, 1 of 1 sprinkler head in the laundry room, behind the dryers was coved in dust or showed signs of loading. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3. Based on observation and interview, the facility failed to maintain the ceiling construction of 2 of 2		· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **The Maintenance Director or designee will ensure that an appropriate type and number of sprinkler heads are securely stored in an approved cabinet, sprinkler heads will be inspected to ensure they are free of foreign material, and ceiling tiles are properly placed.** · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **The Maintenance Director or designee will conduct an audit of the spare sprinkler heads to ensure an appropriate number of each type are securely stored in an approved cabinet, inspect sprinkler heads to ensure they are free of load or foreign material, and inspect ceiling tiles for secure and proper placement; weekly x 4 weeks monthly x 3 months, and quarterly until the QAPI committee determines that substantial compliance has been accomplished. If 95% compliance is not achieved an action plan will be implemented**.	

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	rooms. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 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 affects 4 residents. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:10 a.m. to 1:55 p.m. on 02/16/23, in the (1) therapy area the suspended ceiling was missing at least two tiles. This condition could delay the activation of the sprinklers installed on the suspended ceiling. Based on interview at the time of the observations, the Maintenance director agreed there were missing tiles and stated that work had recently been done on the roof and that was the reason the tiles were missing. The Maintenance Director also stated no work was being done on the day of this survey. Additionally, (2) ceiling tile were missing in the 2nd floor Medical Room at the nurses station. These findings were acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 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			

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	155160	A. BUILDING 01 B. WING	02/16/2023

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	Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the maintenance area was 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 staff in the maintenance area. Findings include: Based on observations and interview with the Maintenance Director and Administrator during a tour of the facility from 11:10 a.m. to 1:55 p.m. on 02/16/23, an ABC portable fire extinguisher in the Maintenance Area was sitting on the floor and was unsecured. Based on interview at the time of observation, the Maintenance Director agreed the extinguisher was unsupported. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)	K 0355	· what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **The fire extinguisher has been returned to vendor for recharging or replacement.** · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. **All residents have the potential to be affected. All other fire extinguishers have been audited to ensure they are properly stored in an approved manner.** · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **The Maintenance Director or designee ensure proper placement of all fire extinguishers at least monthly during the routine extinguisher check.** · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **The Maintenance Director or**	04/03/2023

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			designee will conduct an audit weekly x 4 weeks monthly x 3 months, and quarterly until the QAPI committee determines that substantial compliance has been accomplished. If 95% compliance is not achieved an action plan will be implemented.	
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			

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	other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 2 residents. Findings include: Based on observations and interview with the Maintenance Director during a tour of the facility from 11:10 a.m. to 1:55 p.m. on 02/16/23, the corridor door to Resident Room 113 failed to close and latch positively into the door frame. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned corridor door did not close and latch into the door frame and would not resist the passage of smoke. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)	K 0363	· what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **The door to room 113 has been adjusted and now closes properly.** · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. **All residents have the potential to be affected by the deficient practice. An audit was conducted of all resident room doors and no other were found that did not close and latch properly.** · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **The Maintenance Director or**	04/03/2023

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			designee will conduct a monthly inspection on all resident room doors. Any door found to not close, and latch properly will be adjusted immediately. If the Maintenance Director is unable to make repairs himself, an outside contractor will be employed to make repair. · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **The Maintenance Director or designee will conduct an audit weekly x 4 weeks monthly x 3 months, and quarterly until the QAPI committee determines that substantial compliance has been accomplished. If 95% compliance is not achieved an action plan will be implemented**.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure electrical outlets were protected in all resident rooms according to 19.5.1. NFPA 70,	K 0511	· what corrective action(s) will be accomplished for those residents found to have been	04/03/2023

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	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 2 residents. Findings include: Based on observations and interview with the Maintenance Director and Administrator during a tour of the facility from 11:10 a.m. to 1:55 p.m. on 02/16/23, (1) Resident Room # 212 was missing a wall outlet cover protecting the electrical outlet. The wires were stuffed inside the open box and the receptacle box was missing the actual receptacle and cover, exposing the wire. Additionally (2) an outlet receptacle near Resident Room #245 was not secured to the wall and in need of repair. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)		affected by the deficient practice. **The face plates in rooms 212 and 245 were repaired to completely cover the wall opening for the affected residents.** · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. **An audit was conducted of all receptacle faceplates. All faceplates were found to be in compliance or adjusted to cover the wall openings.** · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **The Director of Maintenance or designee will conduct a monthly audit of all receptacle faceplates and make repairs as needed.** · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **The Maintenance Director or designee will conduct an audit weekly x 4 weeks monthly x 3 months, and quarterly until the QAPI committee determines that substantial compliance has**	

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			been accomplished. If 95% compliance is not achieved an action plan will be implemented.	
K 0914 SS=E Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing at all resident rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as	K 0914	· what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **All residents have the potential to be affected however non were found to be affected by**	04/03/2023

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	hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect 35 residents. Findings include: Based on observations and interview with the Maintenance Director and Administrator during a tour of the facility from 11:10 a.m. to 1:55 p.m. on 02/16/23, an itemized listing of inspection and testing electrical outlet receptacles for the First Floor within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated electrical receptacle testing documentation was completed for the Second Floor on 12/8/22 and supporting documentation was provided, however the First Floor had not been done as of the date of this survey. Observations with the Maintenance Director		**the deficient practice.** · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. **All residents have the potential to be affected. Electrical outlet receptacle testing was conducted throughout the facility.** · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **The Maintenance Director or designee will conduct annual electrical outlet receptacle testing at least annually. All issues will be corrected promptly to ensure resident safety. The results will be uploaded into the TELS system and be available for review upon request.** · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **The Maintenance Director will report the results of the Electrical outlet receptacle testing to the Executive Director after completion of the testing. Any issues/concerns**	

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	showed each resident sleeping room on both floors of the facility had multiple electrical receptacles installed at resident bed locations. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)		**will be immediately addressed, and will be reported at the next QAPI Meeting.**	
K 0927 SS=F Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer rooms was provided with a sign indicating that transferring is occurring. NFPA 99 11.5.2.3.1(3) states, the area is posted with signs indicating that trans-filling is occurring and that smoking in the immediate area is not permitted. This deficient practice could affect all residents. Findings include: Based on observations and interview with the Maintenance Director and Administrator during a	K 0927	· what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **All residents in the vicinity of the Oxygen room have the potential to be affected by the deficient practice. A temporary sign was placed on the door immediately, indicating when transfilling is occurring.** · how other residents having	04/03/2023

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	tour of the facility from 11:10 a.m. to 1:55 p.m. on 02/16/23, the oxygen storage/transfer room did not have a posted sign indicating making a clear distinction between when transferring of oxygen is occurring in this location and when it is not. Based on interview at the time of observation, the Maintenance Director stated there was not a sign stating when trans-filling oxygen is occurring and when it is not. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)		the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. **All residents near the Oxygen room had the potential to be affected however no residents were affected. A permanent transfilling is occurring/Open sign has been ordered and will be affixed to the door when it arrives.** · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **All staff with the ability and training to transfill oxygen will be inserviced on the use of the new signage.** · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **The Maintenance Director of Designee will observe the sign during monthly rounds. Any issues with the signage will be corrected promptly.**	