STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155695	A. BUILDING -- B. WING	10/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVERSIDE VILLAGE	1400 W FRANKLIN ST ELKHART, IN 46516

(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: 10/31/22 Facility Number: 003075 Provider Number: 155695 AIM Number: 200364160 At this Emergency Preparedness survey, Riverside Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 97 certified beds. At the time of the survey, the census was 79. Quality Review completed on 11/03/22	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/31/22 Facility Number: 003075 Provider Number: 155695 AIM Number: 200364160 At this Life Safety Code survey, Riverside Village was found not in compliance with Requirements	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after 11/23/22.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Terry Tomasi	Executive Director	11/19/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke alarms were installed in the resident rooms. The building is fully protected by a 250 kW diesel powered emergency generator. The facility has a capacity of 97 and had a census of 79 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except a detached shed used for storage. Quality Review completed on 11/03/22			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 1) Based on observation and interview, the facility failed to ensure 3 of 12 basement room doors were able to open from the inside if locked. LSC 19.2.2.1 states doors complying with 7.2.1 shall be	K 0211	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Infection	11/23/2022

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	permitted. 7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied. This deficient practice could staff in the basement. Findings include: Based on observation with the Maintenance Director and the Administrator on 10/31/22 between 11:30 a.m. and 12:00 p.m., the activities storeroom door, the clothing storage room door, and the marketing office door were locked with padlocks from the outside and there was no release from the inside to open the doors if lock with the padlocks. This condition could trap a person inside the rooms if locked from the outside. Based on interview at the time of observation, the Maintenance Director and the Administrator agreed three doors were locked with padlocks and could not open from the inside when locked. 2) Based on observation and interview, the facility failed to ensure 2 of 2 exit doors from the furnace room and the biohazard room only contained one latching mechanism to release the door and open. LSC 7.2.1.5.10 states a latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions. 7.2.1.5.10.4 states the releasing mechanism shall open the door leaf with not more than one releasing operation. 7.2.1.5.10.1 states the releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches, above the finished floor. This deficient practice could staff in the basement. Findings include:		Preventionist immediately replaced carts in resident care areas with wheeled isolation carts. Maintenance Director removed padlocks from the basement doors of activity storage room, clothing storage room and marketing storage room. Installed new doorknobs with locking mechanism for in and out egress. 2. 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; A facility audit will be completed by Maintenance Director/designee to validate no padlocks or deadbolts remain on any doors within the facility. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; ED/designee will in-service staff on isolation carts and the use of padlocks or deadbolts is not allowed on doors within the facility on or before 11/23/2022. 4. 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; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance	

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	Based on observation with the Maintenance Director and the Administrator on 10/31/22 between 11:30 a.m. and 12:00 p.m., the furnace room and the biohazard room exit doors in the basement were equipped with two latching devices, a latching door turn knob and a separate deadbolt lock. Based on interview at the time of observation, the Maintenance Director agreed the two exit doors were equipped with two latching devices. 3) Based on observation and interview, the facility failed to ensure 4 of 4 corridor means of egresses were continuously maintained free of obstructions. LSC 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 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 affects 50 residents in the facility. Findings include: Based on an observation with the Maintenance Director and the Administrator on 10/31/22 between 11:30 a.m. and 1:00 p.m., in the 100, 300,		Director/designee will be responsible for completing the QAPI Audit tool “Isolation Equipment” and “Door Lock Check” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up 5. By what date the systemic changes for each deficiency will be completed: November 23, 2022	

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	and 400 resident halls Personal Protective Equipment (PPE) carts were in use but were not equipped with wheels allowing the carts to be move out of the halls during an emergency. The PPE carts were observed by rooms, 409, 303, 110, and 105. Based on an interview at the time of observations, the Maintenance Director stated the PPE carts are not equipped with wheels and would need to be replaced with a PPE cart with wheels. These findings were reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)			
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			

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	safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 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.			

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	18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 8 exit doors were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 15 residents in one exit corridor. Findings include: Based on observation with the Maintenance Director on 10/31/22 at 12:43 p.m., the employee exit door was marked as a facility exit, was magnetically locked, and could be opened by entering a four-digit code on the access control pad, but the code was not posted at the exit. Based on interview at the time of observation, the Maintenance Director agreed the code to open the exit door was not posted by the access control pad. The finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)	K 0222	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Maintenance Director immediately placed the four-digit code on the access control pad of employee exit door to ensure means of egress. 2. 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; A facility audit will be completed by Maintenance Director/designee to validate the four-digit code is on the access control pad of exit doors to ensure means of egress. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; ED/designee will in-service staff on the exit doors requiring to have a four-digit code on the access control pad to ensure means of egress on or before 11/23/22. 4. 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; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be	11/23/2022

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			responsible for completing the QAPI Audit tool and "Door Code Check" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: November 23, 2022	
K 0226 SS=E Bldg. 01	NFPA 101 Horizontal Exits Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 Based on observation and interview, the facility failed to ensure 2 of 3 horizontal exit fire door sets were arranged to automatically close and latch. LSC section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic closing. In addition, NFPA 80, the Standard for Fire Doors and Other Opening Protectives, section 6.1.4.2.1 states self-closing doors shall swing easily and freely and shall be equipped with a closing device to cause the door to close and latch each time it is opened. This deficient could affect 40 residents in 3 smoke compartments. Findings include: Based on observations with the Maintenance	K 0226	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Maintenance Director replaced O2 Room door latch mechanism with new closure device and repositioned Room 410 horizontal exits latch mechanism to ensure self-closure and latching of doors. 2. 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; A facility audit will be completed by Maintenance Director/designee to	11/23/2022

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	Director and Administrator on 10/31/22 at 12:33 p.m., the 3-hour rated fire door sets by the O2 room and room 410 were used as horizontal exits and as smoke barriers. When tested the doors failed to latch into the frame due to the latch catches were not correctly positioned. Based on interview at the time of observation, the Maintenance Director stated the fire door sets were not latching into the frames because the latch catches were no positioned correctly. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		validate fire rated doors properly self-close and latch. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; ED/designee will in-service staff on fire rated doors requiring self-closes and latching on or before 11/23/2022. 4. 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; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Self-Closure Doors with Secure Latch” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: November 23, 2022	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage			

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	2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) 1) Based on record review and interview; the facility failed to install exit signage in 1 of 2 corridors in the basement in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect staff and at least 10 residents. Findings include: Based on observation with the Administrator and Maintenance Director on 10/31/22 at 11:35 a.m. the back corridor in the basement had exit sign the led to a stairwell that could no longer be opened. There was an exit door set back to the left in the old dining room but there were no exit signs leading to the exit door. Based on interview at the time of observation, the Administrator and Maintenance Director acknowledged the aforementioned condition and confirmed that the path of egress was not obvious to the correct exit door. 2) Based on observation and interview, the facility	K 0293	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Maintenance Director installed exit signage to provide a clear path of egress to the back corridor in the basement and placed NO EXIT signage on the stairwell doors in the Memory Care Unit and basement no longer in use. 2. 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; A facility audit will be completed by Maintenance Director/designee to validate exit signage provides clear path of egress and no longer in use exit doors have NO EXIT signage posted. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; ED/designee will in-service staff on exit path signage in basement and no longer used stairwell doors on or before 11/23/2022. 4. How the corrective action(s) will	11/23/2022

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	failed to ensure 2 of 2 inaccessible stairwell doors were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 25 residents in the Memory Care wing. Findings include: Based on observations the Maintenance Director and Administrator on 11/31/22 at 12:22 p.m., in the Memory Care wing and in the basement the stairwell doors that are no longer in use and could be mistaken as facility exits were not posted with "NO EXIT" signs. Based on interview at the time of the observations, the Maintenance Technician stated the stair doors are no longer in use and acknowledged the doors did not have "NO EXIT" signs posted. The findings were reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Door Exit & No Exit Signage” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up 5. By what date the systemic changes for each deficiency will be completed: November 23, 2022	
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			

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	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)			
	1) Based on observation and interview, the facility failed to ensure the corridor doors to 3 of 6 hazardous rooms were protected as a hazardous areas with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 40 residents in two smoke compartments and staff in the basement. Findings include: Based on observations with the Maintenance Director and Administrator on 10/31/22 between	K 0321	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Maintenance Director installed door handle with latch on basement holiday storage room, door closure plate adjusted on soiled utility room by 114 and tape was removed from mechanical room door allowing these doors closure with latching. Maintenance Director applied fire caulking to holes around pipes	11/23/2022

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	155695	A. BUILDING 01 B. WING	10/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVERSIDE VILLAGE	1400 W FRANKLIN ST ELKHART, IN 46516

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	11:30 a.m. and 1:00 p.m., the corridor doors to the following hazardous areas did not meet the requirements for protection of a hazardous area: a) The holiday storeroom which was larger than 50 square feet and contained over 10 boxes of decorations did not have a door handle or latch. b) The soiled utility by room 114 which contained trash and dirty linen did not latch into the frame. c) The mechanical room which contained fuel fired equipment did not latch into the frame due to tape over the door latch. Based on interview at the time of observation, the Maintenance Director agreed all three rooms were hazardous storage areas, and the doors to the rooms did not latch into the door frame. 2) Based on observation and interview, the facility failed to ensure 2 of 2 hazardous rooms that contained fuel fired equipment were separated from other spaces by smoke resistant partitions. This deficient practice could affect 40 residents in two smoke compartments. Findings include: Based on observations with the Maintenance Director and Administrator on 10/31/22 at 12:10 p.m. and at 12:51 p.m., in the mechanical room by room 410 and the floor care room which contained fuel fired equipment each had unsealed holes around pipes and wires. Based on interview at the time of the observation, the Maintenance Director agreed there were unsealed penetration in the mechanical room by room 410 and the floor care room which contained fuel fired equipment. The findings were reviewed with the Administrator and Maintenance Director during the exit conference.		and wires in the floor care closet and mechanical room by 410. 2. 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; A facility audit will be completed by Maintenance Director/designee to validate doors properly close and latch for hazardous rooms. A facility audit will be completed by Maintenance Director/designee to validate no unsealed holes exist in hazardous rooms. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Director/designee will inspect Contractor work area to validate no unsealed holes left around pipes and wiring. ED/designee will in-service staff on proper door closure and latching for hazardous rooms on or before 11/23/2022. 4. 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; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the	

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	3.1-19(b)		QAPI Audit tool "Door Self-Closure with Secure Latch" and "Contractor Inspection" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up 5. By what date the systemic changes for each deficiency will be completed: November 23, 2022	
K 0511 SS=F 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 2 of 4 electrical outlets in the basement hall, 1 of 1 light switches in wheelchair storage, and 1 of 1 receptacle box by the 100-hall exit were protected according to LSC 19.5.1. 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 in the basement and 15 residents in the100-hall. Findings include:	K 0511	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Maintenance Director installed faceplate covers on light switch in wheelchair storage room, two receptacles in back basement corridor and 100-hall exit door. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No	11/23/2022

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	Based on observations with the Maintenance Director and Administrator on 10/31/22 between 11:30 a.m. 1:00 p.m., the following electrical outlets/switches did not have a faceplate: a. Two receptacles in back basement corridor. b. The light switch in the wheelchair storage room. c. The receptacle box which contained wires by the 100-hall exit door. Based on interview at the time of observation, the Maintenance Director agreed the outlet were not covered with faceplates. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		residents were affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Director/designee will inspect Contractor work area to validate no safety hazards requiring an immediate attention. ED/designee to in-service management team on Contractor work areas requiring inspection to validate no safety hazards requiring immediate attention on or before 11/23/2022. 4. 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; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Contractor Inspection” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up 5. By what date the systemic changes for each deficiency will be completed: November 23,	

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			2022	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview; the facility failed to ensure 1 of 1 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect at least 10 staff in the smoking area.	K 0741	K741 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Maintenance Director cleaned cigarette butts	11/23/2022

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	Findings include: Based on observation with the Maintenance Director on 10/31/22 at 12:38 p.m., outside the of employee exit and in the staff smoking area there were over 50 cigarette butts disposed on the ground around the exit and smoking area. Based on interview at the time of observations, the Maintenance Director agree there were cigarette butts on the ground in the staff smoking area. The findings were reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		from employee smoking area and disposed of them in a noncombustible container. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; ED/designee will in-service staff on smoking area and disposal of cigarette butts on or before 11/23/2022. 4. 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; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Smoking Area” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up 5. By what date the systemic changes for each deficiency will	

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			be completed: November 23, 2022	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice affects 2 residents in room 406. Findings include: Based on observations with the Maintenance	K 0920	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Non-medical grade power-strip in room 406 removed and replaced with required UL rating medical grade power strip 2. How other residents having the	11/23/2022

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	Director and the Administrator on 10/31/22 at 12:30 p.m., a power-strip in room 406 was in use within 6 feet of a resident care area that did not meet 1363A or 60601-1. Based on interview at the time of observation, the Maintenance Director agreed power-strip was in use in a resident care area and did not meet 1363A or 60601-1. The findings were reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; A facility audit will be completed by Maintenance Director/designee to validate no non-medical grade power strips in resident care areas 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; ED/designee to in-service staff on UL rating medical grade power strips and allowed usage in resident care areas on or before 11/23/2022. 4. 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; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Power Strip Usage” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up 5. By what date the systemic	

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			changes for each deficiency will be completed: November 23, 2022	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure transfilling of oxygen took place in 1 of 1 oxygen transfilling rooms that are separated from any portion of a facility, NFPA 99 2012 edition 11.5.2.3.1, Transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following: (1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. (2) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring. (3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted. (4) The individual transfilling the container(s) has been properly trained in the transfilling procedures.	K 0927	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Maintenance Director replaced O2 Room door latch mechanism with new closure device to ensure the room door self-closure and latch into the door frame. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No other oxygen storage/transfer rooms within facility. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	11/23/2022

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	This deficient practice could affect up to 21 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director and Administrator on 10/31/22 at 12:05 p.m., the oxygen storage/transfer room contained liquid oxygen tanks, oxygen cylinders, and other oxygen supplies; when the door to the room was tested it did not automatically latch into the door frame. This condition does not separate transfilling from portion of the facility where residents are housed. Based on interview at the time of observation, the Maintenance Director agreed the door did not automatically latch into the door frame. The finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		ED/designee will in-service staff on fire rated door for oxygen storage/transfer room requiring self-closure and latch into the door frame on or before 11/23/2022. 4. 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; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Door Self-Closure with Secure Latch” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up 5. By what date the systemic changes for each deficiency will be completed: November 23, 2022	