STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155022	A. BUILDING -- B. WING	08/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF SHELBYVILLE	2309 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/14/23 Facility Number: 000009 Provider Number: 155022 AIM Number: 100274760 At this Emergency Preparedness survey, The Willows of Shelbyville was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 141 certified beds. At the time of the survey, the census was 63. Quality Review completed on 08/21/23	E 0000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because is required by the provisions of Federal and State Law. Please accept this Plan of Correction as Credible Allegations of Compliance. We respectfully ask for your consideration for paper compliance.	
E 0025 SS=C Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b)(7), 482.15(b)(7), 483.475(b)(7), 483.73(b)(7), 485.625(b)(7), 485.920(b)(6), 494.62(b)(6) Arrangement with Other Facilities §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [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			

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

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	communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain	E 0025	It has been and will continue to be the policy of this facility to develop arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of	09/01/2023

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	the continuity of services to LTC residents in accordance with 42 CFR 483.73(b)(7). This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Administrator and the Maintenance Director on 08/14/23 between 10:20 a.m. and 12:56 p.m., the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations was available for review but the agreements dated back to 2016 and 2017 and with facilities whose names (and likely administrators) have changed. Based on an interview during records review, the Administrator and the Maintenance Director agreed the transfer agreements should be revisited. This finding was acknowledged by the Administrator and the Maintenance Director at the time of discovery and again at the exit conference with the Administrator and the Maintenance Director present.		operations to maintain continuity of services to LTC residents. While all residents had the potential to be affected, nobody was affected by this alleged deficient practice. The facility EOP contains transfer agreements with six facilities. Of those only two of the facilities have changed names since the signing of the transfer agreement, with one of those being the sister facility of this facility that is owned and controlled by the same ownership group. The facility maintains transfer agreements with the buildings or entity's themselves, not with the administrators. All the transfer agreements contained a passage saying, "*This Letter Agreement shall become effective on ____, and shall continue in effect indefinitely, except that a participant may terminate its participation in this letter agreement by giving a sixty (60) day written notice to the other participants of its intentions*." All facility transfer agreements were reviewed and updated as needed (Attachment 1). Administrator and/or designee will review transfer agreements annually during EOP review to ensure all transfer agreements are	

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			still current (Attachment 2). Any updates will be made and adjusted accordingly to recommendations of QA committee. The facility respectfully appeals this finding, within Attachment 1 are the names of the other facilities directly from the ISDH consumer reports showing those buildings are still operational and the same entity.As well as agreements showing the language saying indefinitely unless participant terminates.	
E 0030 SS=C Bldg. --	403.748(c)(1), 416.54(c)(1), 418.113(c)(1), 441.184(c)(1), 482.15(c)(1), 483.475(c)(1), 483.73(c)(1), 484.102(c)(1), 485.625(c)(1), 485.68(c)(1), 485.727(c)(1), 485.920(c)(1), 486.360(c)(1), 491.12(c)(1), 494.62(c)(1) Names and Contact Information §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(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]. The communication plan must include all of the following:] (1) Names and contact information for the following:			

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	(i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians.			

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	(iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes Names and contact information for the following: (i) Staff (ii) Entities	E 0030	It has been and will continue to be the policy of this facility that the facility communication plans includes the names and contact	09/01/2023

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	providing services under arrangement (iii) Residents' physicians (iv) Other LTC facilities (v) Volunteers in accordance with 42 CFR 483.73(c)(1). This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Administrator and the Maintenance Director on 08/14/23 between 10:20 a.m. and 12:56 p.m., the facility's communication plan was not current. The communication plan did not include an updated list of names and contact information for staff, and resident physicians. Based on an interview with the administrator and maintenance supervisor, the plan provided included multiple lists of emergency contact information, some of which contradicted themselves. The Administrator and Maintenance Director agreed that the EPP needed attention and that some of the lists provided contained contact information which was several years outdated. This finding was acknowledged by the Administrator and the Maintenance Director at the time of discovery and again at the exit conference with the Administrator and the Maintenance Director present.		information for staff, entities providing services under arrangement, patients physicians, other, and volunteers. While all residents had the potential to be affected, nobody was affected by this alleged deficient practice. The facility acknowledged many of the names on the list were outdated, but that the facility currently primarily uses a messaging app to communicate with staff so that a change in phone numbers does not negatively affect communication. Facility updated the phone listing within the communication plan (Attachment 3). Administrator and/or designee will update phone listings annually during EOP review to ensure all phone listings are still current (Attach 2). Any updates will be made and adjusted accordingly to recommendations of QA committee.	
E 0031 SS=F Bldg. --	403.748(c)(2), 416.54(c)(2), 418.113(c)(2), 441.184(c)(2), 482.15(c)(2), 483.475(c)(2), 483.73(c)(2), 484.102(c)(2), 485.625(c)(2), 485.68(c)(2), 485.727(c)(2), 485.920(c)(2), 486.360(c)(2), 491.12(c)(2), 494.62(c)(2) Emergency Officials Contact Information §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2),			

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	§485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(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]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan included all applicable sources of assistance. This deficient practice	E 0031	It has been and will continue to be the policy of this facility that the emergency preparedness plan included all applicable sources of	09/01/2023

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	could affect all occupants. Findings include: Based on record review and interview with the Administrator and the Maintenance Director on 08/14/23 between 10:20 a.m. and 12:56 p.m., documentation of the communication plan part of the facility's emergency operations plan reviewed did not include specific contact information, including telephone number, for notification of the State Long Term Care Ombudsman. The Administrator agreed documentation for the communication plan part of the program did not include specific contact information for the office of the State Long Term Care Ombudsman. The emergency operations plan manual was large and contained much information, however the aforementioned contact information for the State Long Term Care Ombudsman could not be located in the plan at the time of the survey. This finding was acknowledged by the Administrator and the Maintenance Director at the time of discovery and again at the exit conference with the Administrator and the Maintenance Director present.		assistance. While all residents had the potential to be affected, nobody was affected by this alleged deficient practice. Upon review the facility located the number of the ombudsman and area 9 agency located within the communications plan. As indicated in the 2567 the manual is quite large and was not found during review. Facility updated the number into a clearer format (Attachment 4 pg. 7). Administrator and/or designee will update phone listings annually during EOP review to ensure all phone listings are still current including the ombudsman and area agency (Attachment 2). Any updates will be made and adjusted accordingly to recommendations of QA committee.	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).			

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	*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients			

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	and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing			

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	participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm			

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	systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the			

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	155022	A. BUILDING -- B. WING	08/14/2023

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	CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on record review and interview with the Administrator and the Maintenance Director on 08/14/23 between 10:20 a.m. and 12:56 p.m., no documentation of annual EPP training and no documentation to show staff could demonstrate knowledge of the EPP was available for review. Based on an interview at the time of records review, the Maintenance Director and Administrator stated training was conducted but could not find the documentation of the EPP training or the demonstration of staff competence on the training. This finding was acknowledged by the Administrator and the Maintenance Director at the time of discovery and again at the exit conference with the Administrator and the Maintenance Director present.	E 0037	It has been and will continue to be the policy of this facility that all staff are trained on the EOP upon hire and at least annually. While all residents had the potential to be affected, nobody was affected by this alleged deficient practice. During record review the facility showed surveyor the signin log for the facility annual EOP training, but was unable to produce the test sheets demonstrating knowledge. Facility did another inservice to ensure staff could demonstrate staff knowledge of emergency operations plan (Attachment 12). Administrator and/or designee will review annual staff training to ensure documentation of staff knowledge of emergency operations plan is included in the EOP. Any staff missing annual education will be immediately educated.	09/13/2023

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/14/23 Facility Number: 000009 Provider Number: 155022 AIM Number: 100274760 At this Life Safety Code survey, The Willows of Shelbyville was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was surveyed as one building of Type V(000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 141 and had a census of 63 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 08/21/23	K 0000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because is required by the provisions of Federal and State Law. Please accept this Plan of Correction as Credible Allegations of Compliance. We respectfully ask for your consideration for paper compliance.	

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K 0200 SS=E 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 always maintain access to 10 of over 30 rooms with keys accessible and no impediments to full instant use in the case of fire or other emergency in accordance with LSC 7.1.10.1. and LSC 19.2.2.2.6 which states doors that are located in the means of egress and are permitted to be locked under other provisions of 19.2.2.2.5 shall comply with all of the following: (1) Provisions shall be made for the rapid removal of occupants by means of one of the following: (a) Remote control of locks (b) Keying of all locks to keys carried by staff at all times (c) Other such reliable means available to the staff at all Times (2) Only one locking device shall be permitted on each door. (3) More than one lock shall be permitted on each door, subject to approval of the authority having jurisdiction. This deficient practice could affect 8 staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 08/14/23 between 12:56 p.m. and 3:55 p.m., the following rooms were not accessible, because keys could not be located during the survey: a) Former RR # 47, being used for storage by the activities department.	K 0200	It has been and will continue to be the policy of this facility that all doors have keys accessible and no other impediments to full instant use. While 8 staff had the potential to be affected, nobody was affected by this alleged deficient practice. The facility acknowledges the maintenance director did not have keys readily available for all rooms listed. The facility's belief is that the regulation cited 19.2.2.2.6 pertains to the egress side of the doors, not the ingress side as cited. 19.2.2.2.4 says, "*Doors within a required means of egress shall not be equipped with a latch or lock that requires a use of tool or key from the **egress side**, unless otherwise permitted by one of the following:"* The facility checked all doors and labeled keys appropriately in order to facilitate accessibility.	09/13/2023

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	b) Former RR 10B, 9B, 6B, 4A, 3B, 2B, 1B all former resident rooms now locked and being used for storage. c) Former RR 5B, now being used for medical records storage. d) The unidentified room across the corridor from 9B. The Maintenance Director spent considerable time during the survey searching for keys to various rooms throughout the facility, at one point requesting assistance from the Administrator, but the keys to the aforementioned rooms were not located and access was not available during the survey. This finding was acknowledged by the Administrator and the Maintenance Director at the time of discovery and again at the exit conference with the Administrator and the Maintenance Director present. 3.1-19(b)		Upon the need to change any door lock in the facility maintenance director will inform administrator or designee as double check that keys are updated and marked appropriately (Attachment 5). The facility respectfully appeals this finding as the doors were locked on the ingress side, not the egress side as the regulation cites. Both 19.2.2.2.2(1) and 19.2.2.2.4 allow for locks on the ingress side as long as they don't prevent egress which these doors did not.	
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			

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	by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4			

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	ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 2 of over 8 exit doors was 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 30, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 08/14/23 between 12:56 p.m. and 3:55 p.m., the (1) exit door near RR# 80 and (2) the exit door on Station 2 near RR #5b, marked as facility exits, were magnetically locked and could be opened by entering a four digit code but the code posted did not open the door and was not the correct code. The Maintenance Director stated that when the codes were changed, apparently the aforementioned doors were missed or had the incorrect code posted. This finding was acknowledged by the	K 0222	It has been and will continue to be the policy of this facility that all exit doors are readily accessible for residents without a clinical diagnosis requiring specialized security measures. While over 30 residents, staff, and visitors had the potential to be affected, nobody was affected by this alleged deficient practice. Maintenance director programmed and affixed new codes to the doors. All doors were checked to ensure codes were correct. Administrator or designee will audit all doors quarterly for the next six months to ensure the codes on the doors are correct and in place (Attachment 7). Any missing or incorrect codes will be replaced/fixed and results taken to quarterly QAPI meeting for review and all recommendations followed.	09/13/2023

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	Administrator and the Maintenance Director at the time of discovery and again at the exit conference with the Administrator and the Maintenance Director present. 3.1-19(b)			
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review, observation and interview; the facility failed to document monthly and annual testing for all battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect over 10 residents, staff and visitors in the Bistro.	K 0291	It has been and will continue to be the policy of this facility that all battery backup lights are tested in accordance with LSC 7.9. While ten residents, visitors, and staff had the potential to be affected, nobody was affected by this alleged deficient practice. Maintenance director was educated on the importance of the testing. All battery operated lights were checked and fixed as needed. Battery operated light in former dialysis unit was removed as not required. Maintenance director or designee will bring his battery backup light log to administrator monthly for review of completeness (Attachment 8). Any issues will be immediately addressed with	09/13/2023

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	Findings include: 1. Based on record review and interview with the Administrator and the Maintenance Director on 08/14/23 between 10:20 a.m. and 12:56 p.m., monthly 30 second and annual 90-minute testing documentation for all battery backup lights was not available for review. Based on observations with the Maintenance Director during a tour of the facility battery operated lighting systems were noted in the facility. The Maintenance Director stated that he had recently installed some Battery Backup lighting systems and that he had not tested them. This finding was acknowledged by the Administrator and the Maintenance Director at the time of discovery and again at the exit conference with the Administrator and the Maintenance Director present. 2. Based on observation and interview, the facility failed to ensure 1 of at least 3 battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either be continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on observations and interview during a		ongoing education and/or progressing discipline provided. Results of audits will be taken to quarterly QAPI meeting for review and all recommendations followed.	

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	tour of the facility with the Maintenance Director on 08/14/23 between 12:56 p.m. and 3:55 p.m., the battery-operated emergency light in the dialysis unit failed to function when its respective test button was pushed three times. It appeared the light was disconnected from the power source. Based on interview at the time of the observations, the Maintenance Director stated battery operated lights in the abandoned dialysis needed to be removed. This finding was acknowledged by the Administrator and the Maintenance Director at the time of discovery and again at the exit conference with the Administrator and the Maintenance Director present. 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. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9			

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	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 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 5 staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 08/14/23 between 12:56 p.m. and 3:55 p.m., the following corridor doors failed to self-close and latch positively into their respective door frames, each were areas greater than 50 square feet containing a mixture of combustible items, such as paper, plastic, cardboard boxes, chairs and furniture: a) The storage room door near RR # 97. b) RR # 58 being used for storage. c) RR # 51 being used for storage. d) RR # 49 being used for storage. e) RR #48 being used for storage. f) The Oxygen Room Storage (not transfilling) room corridor door failed to self-close and latch	K 0321	It has been and will continue to be the policy of this facility that all hazardous storage area doors are provided with properly working self-closing devices. While up to eight staff had the potential to be affected, nobody was affected by this alleged deficient practice. All doors cited in (a) thru (f) were fixed by maintenance and ensured to be properly closing. All other doors were checked and adjusted as needed. The doors which contained hole penetrations were repaired to seal the passage of smoke. All facility staff were inserviced on notifying maintenance of any doors not properly closing or penetrations in doors (Attachment 12).	09/13/2023

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	This finding was acknowledged by the Administrator and the Maintenance Director at the time of discovery and again at the exit conference with the Administrator and the Maintenance Director present. 2. Based on observation and interview, the facility failed to ensure 2 of over 10 hazardous rooms were separated from other spaces by smoke resistant partitions. This deficient practice could affect 8 staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 08/14/23 between 12:56 p.m. and 3:55 p.m., the (1) Linen Room and (2) Soiled Utility room contained hole penetrations in the corridor doors where the door hardware had been removed. Based on interview at the time of the observation, the Maintenance Director agreed there were unsealed penetration in the corridor doors to the aforementioned rooms. This finding was acknowledged by the Administrator and the Maintenance Director at the time of discovery and again at the exit conference with the Administrator and the Maintenance Director present. 3.1-19(b)		Maintenance director or designee will audit one unit weekly for six months to ensure doors on that unit are properly closing (Attachment 9). Any issues will be immediately fixed and results taken to quarterly QAPI meeting for review and all recommendations followed.	
K 0351 SS=F Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic			

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	sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) 1. Based on observation and interview, the facility did not provide adequate signage for 1 of 1 fire department connection (FDC). NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, 13.7 Fire Department Connections. 13.7.1 Fire department connections shall be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. This deficient practice could affect all residents. Findings include:	K 0351	It has been and will continue to be the policy of this facility that proper FDC signs and caps are in place and all escutcheons, or similar metallic devices are in place to protect sprinkler head openings. While six staff had the potential to be affected, nobody was affected by this alleged deficient practice. The FDC connection and missing caps were replaced on the FDC located on the east side of the building. The missing escutcheon in the floor buffer storage room was replaced. All facility staff were inserviced on notifying maintenance of any missing escutcheons (Attachment 12) .	09/13/2023

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	Based on observations and interview during a tour of the facility with the Maintenance Director on 08/14/23 between 12:56 p.m. and 3:55 p.m., the FDC located on the East side of the facility near the exit for Station 1, was not provide with a FDC identification sign. Furthermore, the two caps which screw onto the FDC were missing. Based on interview at the time of observation, the Maintenance Director stated there was no identification sign on the FDC and that he was unaware the caps were missing. This finding was acknowledged by the Administrator and the Maintenance Director at the time of discovery and again at the exit conference with the Administrator and the Maintenance Director present. 2. Based on observation and interview, the facility failed to maintain the ceiling construction in in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. This deficient practice could affect 6 staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 08/14/23 between 12:56 p.m. and 3:55 p.m., 1 of 2 Sprinkler Heads in the Floor Buffer Storage room was missing an escutcheon and did not completely cover the hole around the sprinkler. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned area was missing an escutcheon.		Maintenance director or designee will audit one unit weekly for six months to ensure all escutcheons are in place. Administrator or designee will audit FDC connections quarterly for six months to ensure signs and caps are in place. Any missing items will be immediately replaced and results of audits brought to QAPI for review and all recommendations followed.	

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	This finding was acknowledged by the Administrator and the Maintenance Director at the time of discovery and again at the exit conference with the Administrator and the Maintenance Director present. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on 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	K 0353	It has been and will continue to be the policy of this facility that all spare sprinklers are stored according to NFPA 25 standards and that all sprinkler heads don't show signs of leakage, free of corrosion, foreign materials, paint and physical damage. While four staff had the potential	09/13/2023

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	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 during a tour of the facility with the Maintenance Director on 08/14/23 between 12:56 p.m. and 3:55 p.m., there were two spare sprinkler cabinets, one in each riser room. Two spare sprinklers were sitting loose in the box in riser room #1 and 7 of 13 spare sprinkler heads were sitting loose in the box in riser room #2. They were stored loose in the cabinet and not secured in holders. Based on interview at the time of the observation, the Maintenance Director agreed the spare sprinkler cabinets had spare sprinklers not in protected slots. This finding was acknowledged by the Administrator and the Maintenance Director at the time of discovery and again at the exit conference with the Administrator and the Maintenance Director present. 2. Based on observation and interview, the facility failed to ensure sprinkler heads in the Salon 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		to be affected, nobody was affected by this alleged deficient practice. The spare sprinkler heads were removed from the box or placed in protected slots. Both sprinkler heads in the beauty salon were cleaned. All facility staff were inserviced on notifying maintenance of any dusty or loaded sprinkler heads (Attachment 12). Maintenance director or designee will audit one unit weekly for six months to ensure all sprinkler heads are clean (Attachment 9). Administrator or designee will audit spare sprinkler cabinets quarterly for six months to ensure sprinkler heads are in place. Any issues will be immediately replaced and results of audits brought to QAPI for review and all recommendations followed.	

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	be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff and up to 4 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 08/14/23 between 12:56 p.m. and 3:55 p.m., 2 of 2 sprinkler heads in the Beauty Salon were coved in dust or showed signs of loading. This finding was acknowledged by the Administrator and the Maintenance Director at the time of discovery and again at the exit conference with the Administrator and the Maintenance Director present. 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 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on interview and observation; the facility failed to ensure 1 of 1 office areas were not open to the corridor. LSC 19.3.6.1 states corridors shall be separated from all other areas by partitions	K 0361	It has been and will continue to be the policy of this facility that all areas that open to the corridor are protected appropriately according	10/31/2023

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	complying with 19.3.6.2 through 19.3.6.5 (see also 19.2.5.4), 19.3.6.1 (7) states paces, other than patient sleeping rooms, treatment rooms, and hazardous areas, shall be permitted to be open to the corridor and unlimited in area provided that all of the following criteria are met: (a) The space and the corridors onto which it opens, where located in the same smoke compartment, are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4. (b) Each space is protected by automatic sprinklers, or the furnishings and furniture, in combination with all other combustibles within the area, are of such minimum quantity and arrangement that a fully developed fire is unlikely to occur. (c) The space does not obstruct access to required exits. This deficient practice could affect 15 staff and residents near the old office area. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 08/14/23 between 12:56 p.m. and 3:55 p.m., the old office area on the East Side of the facility was open to the corridor due to the removal of the doors several years ago. No supervised smoke detection was present in the aforementioned office area. Based on interview at the time of observation, the Maintenance Director stated the area had been that way (without doors) for several years and he had not noticed that there was no supervised smoke detection in the area which was now open to the corridor. This finding was acknowledged by the Administrator and the Maintenance Director at the time of discovery and again at the exit conference with the Administrator and the Maintenance Director present.		to LSC 19.3.6.1. While 15 staff had the potential to be affected, nobody was affected by this alleged deficient practice. The facility had previously been cited for this same area on 7/25/2019. At that time the facility placed two monitored smoke detectors in the rooms required. The facility was under the impression they were in compliance with this area/citation. Facility fire protection agency came down and attempted to place an additional monitored smoke detector in the area cited, attic access was limited and the facility will need to make an additional attic access to facilitate the smoke being added. The facility is requesting a temporary waiver due to heat and access within attic to give time for repair. There is a monitored alarm in the hallway currently as well as monitored alarms in the enclosed office. All future renovations, or door removals, changing the smoke compartments within a building will be reviewed by maintenance to ensure adequate smoke detection.	

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	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 resistance of glass or frames in window assemblies.			

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	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 9 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 8 staff and 32 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 08/14/23 between 12:56 p.m. and 3:55 p.m., the following corridor doors failed to latch positively into their respective door frames: a) The corridor door to the dialysis unit, equipped with a self-closing device. b) Resident Room #17 c) The Linen Room on station 1, equipped with a self-closing device, the door sticks on the floor when pushed open and fails to self-close. d) Resident Room #28 e) The kitchen door into the dining area near the icemaker, equipped with a self-closing device. f) The kitchen door into the dietary hall, equipped with a self-closing device. g) The spare clothes room near the dietary hall, equipped with a self-closing device. h) The door from the dining area into the kitchen, tray return area, equipped with a self-closing device. i) Corridor door to the female employee lounge, equipped with a self-closing device.	K 0363	It has been and will continue to be the policy of this facility that all corridor doors have no impediment to closing and latch into the door frame to prevent the passage of smoke. While 8 staff and 32 residents had the potential to be affected, nobody was affected by this alleged deficient practice. Maintenance director and designee repaired, fix, or replaced all doors failing to latch into place and close properly. All staff were inserviced on the importance of doors closing properly (Attachment 12). . Maintenance director or designee will audit one unit weekly for six months to ensure all doors are closing and latching properly (Attachment 9). Any issues will be immediately address and results of audits brought to QAPI for review and all recommendations followed.	09/13/2023

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	This finding was acknowledged by the Administrator and the Maintenance Director at the time of discovery and again at the exit conference with the Administrator and the Maintenance Director present. 3.1-19(b)			
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure all smoke barriers walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing,	K 0372	It has been and will continue to be the policy of this facility that all smoke barrier walls are protected to maintain the smoke resistance of each smoke barrier. While 10 staff and residents had the potential to be affected, nobody was affected by this alleged deficient practice. The area cited is under construction. This unlicensed area was previously a dialysis unit and	09/13/2023

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	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 movement of smoke. This deficient practice could affect staff and at least 10 staff and residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 08/14/23 between 12:56 p.m. and 3:55 p.m., the abandoned dialysis unit had several holes in the walls some measuring as large as 18 inches square. The Maintenance Director stated that equipment had been removed when the unit was shut down and the walls had not been patched. This finding was acknowledged by the Administrator and the Maintenance Director at the time of discovery and again at the exit conference with the Administrator and the Maintenance Director present. 3.1-19(b)		is being discussed with new ownership to turn into possible office space. The areas that equipment was removed were fixed in order to comply with LSC while determining future use. All future renovations where equipment is removed from the wall causing openings for smoke penetration will be audited by administrator or designee for appropriate mitigation during renovation.	
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 1. Based on observation, the facility failed to ensure 1 of 1 electrical junction boxes near the	K 0511	It has been and will continue to be the policy of this facility that all	09/13/2023

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	laundry room were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect 6 staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 08/14/23 between 12:56 p.m. and 3:55 p.m., (1) an electrical junction box in the room under renovation across from the laundry, did not contain a cover and had exposed electrical wiring (ROMEX) hanging out of the box. Based on interview at the time of the observations, the Maintenance Director acknowledged the electrical junction box was not provided with a cover and had exposed wires. And (2) in the abandoned dialysis unit ceiling lights were dangling from their respective wires exposing the ROMEX and wire nuts. This finding was acknowledged by the Administrator and the Maintenance Director at the time of discovery and again at the exit conference with the Administrator and the Maintenance Director present. 2. Based on observation and interview, the facility failed to ensure 1 of over 10 electrical panels in the corridors were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be		junction boxes are maintained in safe operating condition, all electrical panels are secured from unauthorized personnel, and electrical outlets had appropriate face plates. While up to six staff and 14 residents and visitors had the potential to be affected, nobody was affected by this alleged deficient practice. The election junction box and lights within the dialysis unit were fixed to prevent wiring from being exposed. A lock was placed on the electrical panel to prevent unauthorized access and the faceplate was replaced on the receptacle in room 8. All facility staff were inserviced on the importance of looking for exposed wiring or missing faceplates(Attachment 12). Maintenance director or designee will audit one unit weekly for six months to ensure all receptacles have a face plate and no exposed wiring(Attachment 9). Administrator or designee will check all electrical panels quarterly for six months to ensure locks are in place. Any issues will immediately be fixed and results of audits brought to QAPI for review and all recommendations followed.	

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	enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect 6 staff and 14 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 08/14/23 between 12:56 p.m. and 3:55 p.m., one electrical panel behind the cross-corridor door near RR#86 was unlocked when tested. The Maintenance Director stated that he apparently missed that one when he installed locks recently on the corridor panels. This finding was acknowledged by the Administrator and the Maintenance Director at the time of discovery and again at the exit conference with the Administrator and the Maintenance Director present. 3. Based on observation and interview, the facility failed to ensure electrical outlets were protected according to 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 2 residents, 2 staff and			

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	155022	A. BUILDING 01 B. WING	08/14/2023

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	visitors. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 08/14/23 between 12:56 p.m. and 3:55 p.m., in Room labeled 8A one outlet cover protecting the electrical outlet was missing from the receptacle. The Maintenance Director stated he was unsure what had happened to the cover plate. This finding was acknowledged by the Administrator and the Maintenance Director at the time of discovery and again at the exit conference with the Administrator and the Maintenance Director present. 3.1-19(b)			
K 0521 SS=E Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on observation and interview, the facility failed to ensure 5 of 14 egress corridors were not used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. LSC 19.5.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 4.3.12.1.1 states egress corridors shall not be used as a portion of a supply, return, or exhaust air	K 0521	The Heritage House of Shelbyville respectfully requests a waiver for this finding. As previously noted, a waiver was granted in 2022 for the same finding; however, since facility was cited, a new waiver request has been completed (Attachment 10). Smoke and duct detectors were installed which upon activation of the fire alarm system will shut	09/13/2023

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	system serving adjoining areas unless otherwise permitted by 4.3.12.1.3.1 through 4.3.12.1.3.4. This deficient practice could affect over 30 residents, staff and visitors. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 08/14/23 between 12:56 p.m. and 3:55 p.m., all rooms in Station 1 (west wing), Station 2 (east and west wing) and Station 3 were using the egress corridor as a return air system. Based on interview at the time of the observations, the Maintenance Director stated the facility has in the past had a waiver from IDOH for using the corridor as a portion of the HVAC return air system and agreed the aforementioned egress corridors were being using as a return air system. This finding was acknowledged by the Administrator and the Maintenance Director at the time of discovery and again at the exit conference with the Administrator and the Maintenance Director present. 3.1-19(b)		down all of the air handling units. Smoke dampers have also been installed in the ducts which will close upon activation of the fire alarm system thus preventing the transfer of smoke from one smoke/fire zone to another. The units under 2000 CFM capacity have been tied to the central fire alarm system panel enabling the units to shut down upon the activation of the fire alarm system. The facility believes they are in compliance with this regulation. *4.3.12.1.1* *This is one of the more widely misunderstood and misinterpreted paragraphs of this standard. This provision prohibits environmental air from passing from an occupied space to an egress corridor or passing from an egress corridor to an occupied space before it passes through the air distribution system in the occupancies listed.* *NFPA 90A Standard for the Installation of Air-Conditioning and Ventilating Systems Handbook 2015* *NFPA 90A 2015 Handbook Edition* *As an example: One air handler serves the corridor and adjoining patient room. The supply is fully ducted to the corridor and the room. The room return is fully ducted, and the corridor*	

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			return is via the plenum space over the corridor ceiling. There is a wastebasket fire in a patient room. The smoke from it would have to enter the return system directly from the room, where it would go back to the air handler and past the supply side smoke detector, thereby shutting down the unit before it could deliver the smoke-contaminated air back to the corridor. Conversely, there is a wastebasket fire in the corridor. The smoke from it would have to enter the return system plenum directly from the corridor, where it would go back to the air handler and past the supply side smoke detector, thereby shutting down the unit before it could deliver the smoke-contaminated air back to the patient room. The intent is to prohibit smoke-contaminated air moving, in either direction, directly from one occupied space (patient room) to another occupied space (corridor). The subparagraphs below are essentially exceptions to the requirement in 4.3.12.1.1 (Attachment 13) The facility's last estimate was nearly one hundred thousand dollars to fix the deficiency. This was prior to the pandemic and astronomical increase in pricing to	

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			all the industry trades. (Attachment 10) The facility respectfully appeals this finding due to the above interpretive guidance. The system shutdowns would prevent smoke from transferring from one occupied space to another.	