STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155199	A. BUILDING -- B. WING	11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE PARK VILLAGE	776 N UNION ST WESTFIELD, IN 46074

(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: 11/14/22 Facility Number: 000106 Provider Number: 155199 AIM Number: 100266390 At this Emergency Preparedness survey, Maple Park Village was found to be in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 106 certified beds. At the time of the survey, the census was 89. Quality Review on 11/17/22	E 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. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 12/14/22.	
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: 11/14/22 Facility Number: 000106 Provider Number: 155199 AIM Number: 100266390 At this Life Safety Code survey, Maple Park Village was found not in compliance with	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. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 12/14/22.	

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

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 106 and had a census of 89 at the time of this survey. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review on 11/17/22			
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation and interview, the facility failed to meet the clear width requirement for 2 of over 5 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following	K 0232	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The large table has been removed from the area between	12/14/2022

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	conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by LSC 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in LSC 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with LSC 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with LSC 19.3.5.8 This deficient practice could affect 20 residents, staff and visitors exiting the facility. Findings: Based on observations during a facility tour and interview with the Maintenance Supervisor on 11/14/22 between 11:50 a.m. and 3:15 p.m., the corridor between resident rooms 312 & 314 contained a large table which extended into the corridor. The aforementioned table was free standing, not affixed to the wall or floor.		312 and 314 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · No residents were affected by the alleged deficient practice. · All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Staff have been in-serviced on ensuring corridors are continuously maintained free of all obstructions · A Maintenance audit tool will be completed monthly for one year to ensure all means of egress are being maintained · A visual inspection by the Executive Director or designee has been completed to ensure all means of egress are being maintained **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?** · A Maintenance audit tool, ensuring corridors are continuously maintained free of all	

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	The finding was acknowledged at the time of discovery and again at the exit conference with the Executive Director and Maintenance Supervisor present. 3.1-19(b)		obstructions, will be completed monthly for one year with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Any non compliance with staff will result in staff education and up to disciplinary action	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of 8 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect 25 residents and staff using the Breezeway North Exit. Findings include: Based on observations during a facility tour and interview with the Maintenance Supervisor on 11/14/22 between 11:50 a.m. and 3:15 p.m., the exit discharge described as the Breezeway North Exit, was uneven. Where the sidewalk sloped and	K 0271	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · There will be a new concrete ramp installed to the street by 12/14/22 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · No residents were affected by the alleged deficient practice. · All residents, visitors, staff	12/14/2022

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	terminated to the parking lot, a fence has been erected around the generator which obstructs the exit discharge and at all other points the sidewalk has a curb of approximately 6 inches before stepping down to the parking lot. The Maintenance Supervisor agreed that the sidewalk only slopes to the parking lot at the point where the fence is obstructing access and the facility did not have a complete level walking surface that was free of obstructions leading to the common way at this exit location. The finding was acknowledged at the time of discovery and again at the exit conference with the Executive Director and Maintenance Supervisor present. 3.1-19(b)		have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · staff will be inserviced by the Executive Director/designee on level walking surfaces, are free of obstructions, and constructed of hard packed all-weather travel surface and the regulatory standard indicated by this requirement by 12/14/22. · The Maintenance Supervisor/designee will make environmental rounds daily to ensure facility exits remain clear of obstructions. **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?** · A Maintenance audit tool, ensuring corridors are continuously maintained free of all obstructions, will be completed monthly for 6 months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Any non compliance	

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			with staff will result in staff education and up to disciplinary action	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 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 observation and interview, the facility failed to ensure the 200 North Exit was clearly identified 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 10 residents. Findings include: Based on observations during a facility tour and interview with the Maintenance Supervisor on 11/14/22 between 11:50 a.m. and 3:15 p.m., the exit door identified as the "North 200 Exit" had an illuminated exit sign above the door. Additionally, on the door, there was a sign indicating the door was not an exit from the facility leading into the courtyard. This condition creates confusion	K 0293	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Remove “Not an Exit” Sign at the end of the 200 hall and install a “Not and Exit” Sign on the memory courtyard door. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · No residents were affected by the alleged deficient practice. · All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic**	12/14/2022

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	regarding the ability to escape/evacuate the facility via the aforementioned door. Based on interview at the time of the observations, the Maintenance Supervisor was unsure if the exit was a required exit and was also unsure why the "not an exit" signage was on the door. The finding was acknowledged at the time of discovery and again at the exit conference with the Executive Director and Maintenance Supervisor present. 2. Based on observation and interview, the facility failed to ensure 1 of 1 courtyard doors to the outside of the facility was 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 area. Findings include: Based on observations during a facility tour and interview with the Maintenance Supervisor on 11/14/22 between 11:50 a.m. and 3:15 p.m., in the Memory Care area leading to the courtyard the door to the outside courtyard was not an exit door and the door was not posted with a "NO EXIT" sign. Based on interview at the time of the observation, the Maintenance Supervisor stated the courtyard is not an exit to the public way and acknowledged the courtyard door did not have a "NO EXIT" sign posted and he believed it was		**changes you will make to ensure that the deficient practice does not recur?** · The Maintenance Supervisor will be inserviced by the Executive Director/designee on the regulatory standard indicated by this requirement by December 14, 2022 · A Maintenance audit tool will be completed monthly for one year to ensure all exit signage is meeting the regulatory requirements · A visual inspection by the Executive Director or designee has been completed to ensure all exit signage is meeting the regulatory requirements · **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?** · A Maintenance audit tool, ensuring exit signage is meeting the regulatory requirements, will be completed monthly for 6 months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure	

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	once there but had been removed. The finding was acknowledged at the time of discovery and again at the exit conference with the Executive Director and Maintenance Supervisor present. 3.1-19(b)		compliance. Any non compliance with staff will result in staff education and up to disciplinary action	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchen. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be	K 0324	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The Dietary Manager and	12/14/2022

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	reviewed with employees by management. This deficient practice could affect staff in the kitchen and 25 residents in the dining room. Findings include: Based on observations during a facility tour and interview with the Maintenance Supervisor on 11/14/22 between 11:50 a.m. and 3:15 p.m., the kitchen contained a UL 300 hood system and a K-class fire extinguisher with posted instructions. Instructions were also placed near the UL 300 Hood Pull stating, "in the event of a grease fire, under the hood, first use the K-Class fire extinguisher. If the K-Class doesn't extinguish the fire, then use the UL 300 Suppression system by pulling the ring." Based on interview, the facilities 1 of 1 mid-morning cook was asked; what is the correct response if there was a grease fire underneath the hood. The employee responded by looking under the hood for some switch. The employee failed to identify the location of either the pull station or the K Class extinguisher. The Maintenance Supervisor acknowledged the response and stated additional training would be necessary. And the sign over the UL 300 Pull station would need to be removed. The finding was acknowledged at the time of discovery and again at the exit conference with the Executive Director and Maintenance Supervisor present. 3.1-19(b)		kitchen staff have been re-educated on the use of the UL 300 hood system in the kitchen. Training included the instructions for manually operating the fire extinguishing system. · The sign was removed **How other residents having the potential to be affected by the same deficient practice will be identified and who corrective action(s) will be taken?** · No residents were affected by the alleged deficient practice. · All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** · The Dietary Manager and dietary staff were provided in-service training on the use of the UL 300 hood system in the kitchen, in the event of a fire, Training included the instructions for manually operating the fire extinguishing system, education completed by December 14, 2022. · There is a posting of the instructions on how to manually operate the fire extinguishing system. · The Executive Director/designee will monitor kitchen staff training and in-service	

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			to ensure compliance. · A Maintenance audit tool will be completed monthly for 6 months to ensure Dietary staff understand the use of the UL 300 hood system in the event of a fire **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** · A Maintenance audit tool will be completed monthly, to ensure staff understand the use of the UL 300 hood system in the event of a fire and the results of the monitoring will be reviewed during the Quality Assurance Performance Improvement (QAPI) monthly meeting for 6 months, QAPI is overseen by the Executive Director. Any non compliance with staff will result in staff education and up to disciplinary action.	
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 sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative			

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	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)			
	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: Based on observations during a facility tour and interview with the Maintenance Supervisor on 11/14/22 between 11:50 a.m. and 3:15 p.m., the Fire	K 0351	**What corrective action(s) will be accomplished for those residents found to have been** · Installed new directional FDC signs **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · No residents were affected by the alleged deficient practice. · All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The Maintenance Supervisor will be inserviced by the Executive Director/designee on the regulatory standard	12/14/2022

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	Department Connection is located on the rear Eastward side of the facility, the entrance to the facility is on the opposite Westward side of the building. The facility failed to provide a FDC identification sign directing emergency responders entering the facility parking lot from the front Westward side of the facility to the FDC location in the rear. Based on interview at the time of observation, the Maintenance Supervisor acknowledged there was no identification sign directing responders entering the main front parking lot to the FDC on the rear Eastward side of the building. This deficient practice would make it difficult for responding fire personnel to quickly locate the FDC attached the facility. The finding was acknowledged at the time of discovery and again at the exit conference with the Executive Director and Maintenance Supervisor present. 3.1-19(b)		indicated by this requirement December 14, 2022. · A Maintenance audit tool will be completed monthly, to ensure the FDC directional signage is in place **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?** · A Maintenance audit tool will be completed monthly, to ensure the FDC directional signage is in place and the results of the monitoring will be reviewed during the Quality Assurance Performance Improvement (QAPI) monthly meeting for 6 months, QAPI is overseen by the Executive Director. Any non compliance with staff will result in staff education and up to disciplinary action.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked			

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(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
	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 Based on observation and interview, the facility failed to ensure sprinkler heads in the kitchen were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect 5 staff. Findings include: Based on observations during a facility tour and interview with the Maintenance Supervisor on 11/14/22 between 11:50 a.m. and 3:15 p.m., the sprinkler heads in the kitchen near the dishwasher were coved in dust or showed signs of loading. This finding was acknowledged by the Maintenance Supervisor at the time of observation who stated he was aware of the issue and that they were scheduled to be replaced. The finding was acknowledged at the time of discovery and again at the exit conference with	K 0353	**What corrective action(s) will be accomplished for those residents found to have been** · Sprinkler heads in the kitchen were already on order and are to be replaced 12/14/22 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · No residents were affected by the alleged deficient practice. · All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The Maintenance Supervisor will be inserviced by the Executive Director/designee on the regulatory standard indicated by this requirement December 14, 2022.	12/14/2022

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	the Executive Director and Maintenance Supervisor present. 3.1-19(b)		· A Maintenance audit tool will be completed monthly, to ensure sprinkler heads are not covered in dust or showing signs of loading. **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?** · A Maintenance audit tool will be completed monthly , to ensure sprinkler heads are not covered in dust or showing signs of loading and the results of the monitoring will be reviewed during the Quality Assurance Performance Improvement (QAPI) monthly meeting for 6 months, QAPI is overseen by the Executive Director. Any non compliance with staff will result in staff education and up to disciplinary action.	
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			

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	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. 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.			
	1. Based on observation and interview, the facility failed to ensure 2 of over 30 corridor doors would resist the passage of smoke. This deficient practice could affect 8 residents. Findings include:	K 0363	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The holes at the handles of the doors has been fixed.	12/14/2022

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	Based on observations during a facility tour and interview with the Maintenance Supervisor on 11/14/22 between 11:50 a.m. and 3:15 p.m., the following corridor doors had holes which penetrated completely through the door: A) A 1/2 inch hole through the door above the latching hardware in the corridor door to resident room 105. B) A 1/2 inch hole through the door above the latching hardware in the corridor door to the Social Services Office. The finding was acknowledged at the time of discovery and again at the exit conference with the Executive Director and Maintenance Supervisor present. 2. Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 2 staff and 5 residents in the activities area. Findings include: Based on observations during a facility tour and interview with the Maintenance Supervisor on 11/14/22 between 11:50 a.m. and 3:15 p.m., the corridor door to the activities area failed to close and latch positively into the door frame. The finding was acknowledged at the time of discovery and again at the exit conference with the Executive Director and Maintenance Supervisor present. 3.1-19(b)		· Adjusted the latch and replaced the hinge to the Activities door **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · No residents were affected by the alleged deficient practice. · All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The Maintenance Supervisor will be inserviced by the Executive Director/designee on the regulatory standard indicated by this requirement December 14, 2022. ·Maintenance Supervisor/designee completes preventative maintenance tasks via TELs system which includes testing fire doors, and submits completion to the ED during monthly QAPI meeting. · A Maintenance audit tool will be completed monthly, to ensure there are no holes of the doors near the handles and the activities door latches correctly **How the corrective action(s)**	

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			will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · A Maintenance audit tool will be completed monthly , to ensure there are no holes of the doors near the handles and the activities door latches correctly and the results of the monitoring will be reviewed during the Quality Assurance Performance Improvement (QAPI) monthly meeting for 6 months, QAPI is overseen by the Executive Director. Any non compliance with staff will result in staff education and up to disciplinary action.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility	K 0374	**What corrective action(s) will**	12/14/2022

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	failed to ensure 1 of 5 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect 24 residents. Findings include: Based on observations during a facility tour and interview with the Maintenance Supervisor on 11/14/22 between 11:50 a.m. and 3:15 p.m., the set of smoke barrier doors (1) near resident room #101 and (2) near the clean utility area on the 200 Hall, did not close completely and latch. Based on interview during the time of observations, the Executive Director acknowledged these smoke barrier doors did not close completely and latch. The finding was acknowledged at the time of discovery and again at the exit conference with the Executive Director and Maintenance Supervisor present. 3.1-19(b)		**be accomplished for those residents found to have been affected by the deficient practice?** · Door had already been ordered and set to be replaced 12/14/22 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · No residents were affected by the alleged deficient practice. · All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·The Maintenance Supervisor will be inserviced on the regulatory standard indicated by this requirement by December 14, 2022. ·Maintenance Supervisor completes preventative maintenance tasks via TELs system which includes testing fire doors, and submits completion to the ED during monthly QAPI meeting. · A Maintenance audit tool will be completed monthly, to ensure the smoke barrier doors close completely and latch .	

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			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? · A Maintenance audit tool will be completed monthly , to ensure the smoke barrier doors close completely and latch and the results of the monitoring will be reviewed during the Quality Assurance Performance Improvement (QAPI) monthly meeting for 6 months, QAPI is overseen by the Executive Director. Any non compliance with staff will result in staff education and up to disciplinary action.	
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 and interview, the facility failed to ensure all 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 enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed	K 0511	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The panel has been locked · The wires have been removed	12/14/2022

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	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 staff and 12 residents. Findings include: Based on observations during a facility tour and interview with the Maintenance Supervisor on 11/14/22 between 11:50 a.m. and 3:15 p.m., two electrical panels in the 200 hall near resident room 216 were unlocked when tested. The finding was acknowledged at the time of discovery and again at the exit conference with the Executive Director and Maintenance Supervisor present. 2. Based on observation and interview, the facility failed to ensure 1 of 1 electrical boxes in the Riser room was 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 3 staff. Findings include:		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · No residents were affected by the alleged deficient practice. · All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·The Maintenance Supervisor will be inserviced by the Executive Director/designee on the regulatory standard indicated by this requirement by December 14, 2022. ·Maintenance Supervisor completes preventative maintenance tasks via TELs system which includes checking electrical wiring and outlets, and submits completion to the ED during monthly QAPI meeting · A Maintenance audit tool will be completed monthly, to ensure the electrical panels are locked and there are no exposed wires in the riser room **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	Based on observations during a facility tour and interview with the Maintenance Supervisor on 11/14/22 between 11:50 a.m. and 3:15 p.m., in the sprinkler riser area there was an electrical receptacle that had a heavy gauge wire coming from the bottom. The wire was hung over a support and had 3 wire nuts at the terminals. The Maintenance Supervisor stated he was unsure why the wire was exposed and left in that condition. The finding was acknowledged at the time of discovery and again at the exit conference with the Executive Director and Maintenance Supervisor present. 3.1-19(b)		**assurance program will be put into place?** · A Maintenance audit tool will be completed monthly, to ensure the electrical panels are locked and there are no exposed wires in the riser room and the results of the monitoring will be reviewed during the Quality Assurance Performance Improvement (QAPI) monthly meeting for 6 months, QAPI is overseen by the Executive Director. Any non compliance with staff will result in staff education and up to disciplinary action.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills or documented orientation training on all second quarter shifts. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance	K 0712	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Maintenance	12/14/2022

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	engineers, and administrative staff) with the signals and emergency action required under varied conditions. QSO-20-31 1135 temporary waiver states in lieu of a physical fire drill, a documented orientation training program related to the current fire plan, which considers current facility conditions, is acceptable. The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area. This deficient practice affects all staff and residents. Findings include: Based on record review and interview with the Maintenance Supervisor on 11/14/22 between 10:00 a.m. and 11:50 a.m., the facility was missing documentation of a completed fire drill for all three shifts during the second quarter of 2022. Based on interview at the time of record review, the Maintenance Supervisor agreed there were missing fire drills and staff has not been trained in the fire safety procedures for the second quarter of 2022 stating that the Maintenance Director during that time period likely did not complete fire drills. The finding was acknowledged at the time of discovery and again at the exit conference with the Executive Director and Maintenance Supervisor present. 3.1-19(b) 3.1-51(c)		Director/designee will make sure to do fire drills per state regulations moving forward **How other residents having the potential to be affected by the same deficient practice will be identified and who corrective action(s) will be taken?** · No residents were affected by the alleged deficient practice. · All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** ·The Maintenance Supervisor will be inserviced by the Executive Director/designee on the regulatory standard indicated by this requirement by December 14, 2022. ·Maintenance Supervisor completes preventative maintenance tasks via TELs system which includes fire drills, and submits completion to the ED during monthly QAPI meeting · Maintenance Director/designee will make sure to do fire drills per state regulations moving forward **How the corrective action(s)**	

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			will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place? · A Maintenance audit tool will be completed monthly, to ensure the fire drills are completed per state regulations and the results of the monitoring will be reviewed during the Quality Assurance Performance Improvement (QAPI) monthly meeting for 6 months, QAPI is overseen by the Executive Director. Any non compliance with staff will result in staff education and up to disciplinary action.	
K 0741 SS=F 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			

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	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 3 of 3 smoking areas and 1 of 1 non-smoking areas were maintained by disposing cigarette butts a metal or noncombustible container with self-closing cover devices. This deficient practice could affect all residents. Findings include: Based on observations during a facility tour and interview with the Maintenance Supervisor on 11/14/22 between 11:50 a.m. and 3:15 p.m., the following was observed: a) Around the Maintenance Shop Entrance there were over 50 cigarette butts disposed on the ground in the gravel near the building. b) In and around the Smoking Area there were over 20 cigarette butts disposed on the ground in the smoking area and in and around the leaves near the area. c) Near the exit by the FDC sign, there were over 20 cigarette butts on the ground. d) Near the Riser Room, there were over 100 cigarette butts on the ground in the gravel and near the building. The finding was acknowledged at the time of discovery and again at the exit conference with	K 0741	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The Cigarette butts have been cleaned up in the identified areas **How other residents having the potential to be affected by the same deficient practice will be identified and who corrective action(s) will be taken?** · No residents were affected by the alleged deficient practice. · All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** · staff will be inserviced by the Executive Director/designee on non smoking areas and	12/14/2022

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	the Executive Director and Maintenance Supervisor present. 3.1-19(b)		smoking areas are maintained by disposing cigarette butts in a metal or noncombustible container with a self closing cover device · The Maintenance Supervisor/designee will make environmental rounds daily to ensure facility non smoking and smoking areas are maintained and cigarette butts are disposed in a metal or noncombustible container with a self closing cover device **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** · A Maintenance audit tool will be completed monthly, to ensure facility non smoking and smoking areas are maintained and cigarette butts are disposed in a metal or noncombustible container with a self closing cover device and the results of the monitoring will be reviewed during the Quality Assurance Performance Improvement (QAPI) monthly meeting for one year, QAPI is overseen by the Executive Director. Any non compliance with staff will result in staff education and up to disciplinary action.	

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K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing at all resident rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not	K 0914	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The electrical testing of receptacles has been completed and documented on the proper forms	12/14/2022

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	exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all residents. Findings include: Based on record review, observation and interview with the Maintenance Supervisor on 11/14/22 between 10:00 a.m. and 11:50 a.m., an itemized listing of inspection and testing electrical outlet receptacles for the facility within the most recent twelve-month period was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated that while he was on vacation his assistant began the electrical testing but according to documentation it was not completed. The most recent complete documentation of receptacle testing was dated 04/28/21. Based on observations with the Maintenance Supervisor during a tour of the facility each resident sleeping room had multiple electrical receptacles installed at resident bed locations.		**How other residents having the potential to be affected by the same deficient practice will be identified and who corrective action(s) will be taken?** · No residents were affected by the alleged deficient practice. · All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** ·The Maintenance Supervisor will be inserviced by the Executive Director/designee on the regulatory standard indicated by this requirement by December 14, 2022. ·Maintenance Supervisor completes preventative maintenance tasks via TELs system which includes checking electrical wiring and outlets, and submits completion to the ED during monthly QAPI meeting · Maintenance Director/designee will make sure to do electrical testing of receptacles per state regulations moving forward **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	The finding was acknowledged at the time of discovery and again at the exit conference with the Executive Director and Maintenance Supervisor present. 3.1-19(b)		**recur, ie., what quality assurance program will be put into place?** · A Maintenance audit tool will be completed monthly to ensure electrical testing of receptacles per state regulations and the results of the monitoring will be reviewed during the Quality Assurance Performance Improvement (QAPI) monthly meeting for one year, QAPI is overseen by the Executive Director. Any non compliance with staff will result in staff education and up to disciplinary action.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips 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			

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	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 1. Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 2 residents and 2 staff in the Medical Records office. Findings include: Based on observations during a facility tour and interview with the Maintenance Supervisor on 11/14/22 between 11:50 a.m. and 3:15 p.m., in the Medical Records Office a power strip was being used to power a microwave oven (high power draw equipment). The finding was acknowledged at the time of discovery and again at the exit conference with the Executive Director and Maintenance Supervisor present. 2. Based on observation and interview, the facility failed to ensure power strips in a resident room met UL rating of 1363A or 60601-1. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during	K 0920	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The power strip has been removed from the Medical Records office · The phone charger in resident room 222 has been removed **How other residents having the potential to be affected by the same deficient practice will be identified and who corrective action(s) will be taken?** · All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** · The Director of Maintenance, and staff were provided in-service training on Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, to include information	12/14/2022

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	examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice affects 3 resident. Findings include: Based on observations during a facility tour and interview with the Maintenance Supervisor on 11/14/22 between 11:50 a.m. and 3:15 p.m., resident room 222 was using a power strip for resident's personal electrical equipment items including a cell phone charger. Plugged into the same power strip was an medical IV machine which was in use for patient care. The finding was acknowledged at the time of discovery and again at the exit conference with the Executive Director and Maintenance Supervisor present. 3.1-19(b)		regarding extension cords and surge protectors, by December 14, 2022 · The Maintenance Director/designee will monitor the facility to ensure continued compliance with power cords and extension cord requirements. · A visual inspection by the Maintenance Director/designee has been completed to ensure the surge protectors and extension cords have been removed and if needed replaced with hospital grade surge protectors. · staff will be inserviced by the Executive Director/designee on power strips and proper usage · The Maintenance Supervisor/designee will make environmental rounds daily to ensure facility power strips are being used correctly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** · A Maintenance audit tool will be completed monthly, to ensure continued compliance with power cords and extension cord requirements and the Executive Director will monitor the facility to ensure continued compliance with	

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			power cords and extension cord requirements, for 6 months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Executive Director. Any non compliance with staff will result in staff education and up to disciplinary action	