STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155188	A. BUILDING -- B. WING	08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENFIELD HEALTHCARE CENTER	200 GREEN MEADOWS DR GREENFIELD, IN 46140

(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: 08/24/22 Facility Number: 000099 Provider Number: 155188 AIM Number: 100291140 At this Emergency Preparedness survey, Greenfield Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 163 certified beds. At the time of the survey, the census was 126. Quality Review completed on 08/30/22	E 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the facility's Life Safety Code with Emergency Preparedness Survey. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
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: 08/24/22 Facility Number: 000099 Provider Number: 155188	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal	

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

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	AIM Number: 100291140 At this Life Safety Code survey, Greenfield Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility with a second story equipment area was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery-operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 163 and had a census of 126 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except for four outside sheds which were used for storage. Quality Review completed on 08/30/22		and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the facility's Life Safety Code with Emergency Preparedness Survey. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to maintain latching hardware on 1 of 2 smoke barrier doors per 4.6.12.3. LSC 4.6.12.3	K 0100	**K100** It is the policy of this facility to provide latching hardware on	09/12/2022

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	requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect 25 residents in the TCU hall. Findings include: Based on observations during a tour of the facility with the Maintenance Director 08/24/22 between 12:45 p.m. and 4:45 p.m., the set of barrier double doors near the Physicians Lounge on the TCU Hall did not positively latch. Based on interview during the time of observations, the double barrier doors self-closed and appeared to latch but when mild pressure was applied to one of the doors, it broke free from the latch and reopened, without engaging the opening hardware. The Maintenance Director stated that a screw was missing, and the door set would need to be adjusted to latch properly. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m. 3.1-19(b)		doors. 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? Facility has installed new latching mechanism on the double doors near the physicians lounge on the TCU hallway. 2. How will other residents having the same potential to be affected by the alleged deficient practice be identified and what corrective action will be taken? No residents or visitors were affected by this alleged deficiency. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? Doors are to be checked monthly to ensure they close accordingly. Doors will continue to be checked monthly with repairs / replacements done accordingly. Maintenance has been educated on how to properly check fire doors for appropriate closure. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? The Maintenance Supervisor and/or Designee will ensure that doors are inspected monthly. Maintenance Supervisor and will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring	

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			will continue until this threshold has been reached. 5. By what date will systemic changes be completed? 9/12/2022	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked			

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	space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	1. Based on observation and interview, the facility failed to ensure all exterior exit doors were readily accessible and able to open on first try. This deficient practice could affect 20 occupants in the Brookshire Hall. Findings include: Based on observations during a tour of the facility	K 0222	**K 222** It is the policy of this facility to provide exits at Egresses. 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? The facility received a proposal to replace the door to the exit by the	09/12/2022

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	with the Maintenance Director 08/24/22 between 12:45 p.m. and 4:45 p.m., the exit door on the Brookshire Hall near the Generator would not open when easily on the first try when tested. The Surveyor, then the Maintenance Director tried to open the door, and the Maintenance Director was able, after considerable effort to open the exit door. The Maintenance Director stated that there was swelling and rust which builds up on the door frame because it is not used often. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m. 2. Based on observation and interview, the facility failed to ensure the means of egress through the courtyard exit 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 15, staff and visitors if needing to exit the facility. Findings include: Based on observations during a tour of the facility with the Maintenance Director 08/24/22 between 12:45 p.m. and 4:45 p.m., the exit door from the corridor into the main courtyard, was marked as a facility exit, was magnetically locked and could be opened by entering a four-digit code but the code was not posted at the exit.		generator on the brookshire hall and was approved. Facility is just waiting for new door to arrive and be installed. The code has been posted accordingly to the exit door from the corridor into the main courtyard. 2. How will other residents having the same potential to be affected by the alleged deficient practice be identified and what corrective action will be taken? No residents were affected by this alleged deficiency. The code has been posted and a new door was purchased. No other areas identified during inspection. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? The exit door near the generator on the brookshire hallway and the gate in the courtyard will be inspected monthly to ensure the door can open with ease and the code is posted in the courtyard area. Staff educated as to where to find posted code. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? The Maintenance Supervisor and/or Designee will ensure that code is posted monthly. Maintenance Supervisor will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of	

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	This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m. 3.1-19(b)		the 6 months, then the monitoring will continue until this threshold has been reached. 5. By what date will systemic changes be completed? 9/12/2022	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces			

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	(over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure the corridor doors to 3 of 3 hazardous rooms were provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 40 residents in three smoke compartments. Findings include: Based on observations during a tour of the facility with the Maintenance Director 08/24/22 between 12:45 p.m. and 4:45 p.m., the corridor doors to the following hazardous areas did not meet the requirements for protection of a hazardous area: a) Resident Room #301 which was larger than 50 square feet and contained over 30 boxes of supplies and was not self-closing. b) The Unit Managers Office, which was larger than 50 square feet and contained lots and lots of paper, boxes, and supplies was not self-closing. c) Resident Room #337 which was larger than 50 square feet and contained boxes of supplies, construction equipment, 5 gallon buckets of wall spackle and other debris was not self-closing. Based on interview at the time of observation, the Maintenance Director agreed all 3 rooms were hazardous storage areas, and the doors to the rooms were not self-closing or did not latch into the frame. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m.	K 0321	**K 321** It is the policy of this facility to ensure self-closing devices are present on doors considered to be in hazardous rooms. 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? Facility has installed self-closing devices on doors identified in hazardous rooms. 2. How will other residents having the same potential to be affected by the alleged deficient practice be identified and what corrective action will be taken? No residents or visitors are allowed in this area. The 3 doors identified as hazardous rooms all had self-closing devices installed by maintenance. All doors were to checked to ensure there were no other deficiencies. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? Doors are checked monthly to ensure they close accordingly. Doors will continue to be checked monthly with repairs / replacements done accordingly. Maintenance has been educated on having self-closing devices on doors in hazardous rooms.	09/12/2022

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	3.1-19(b)		4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? The Maintenance Supervisor and/or Designee will ensure that doors are inspected monthly. Maintenance Supervisor and will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached. 5. By what date will systemic changes be completed? 9/12/2022	
K 0351 SS=E 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 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.			

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	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 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 staff and up to 2 staff and 12 residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director 08/24/22 between 12:45 p.m. and 4:45 p.m., (1) a Sprinkler Head outside the main dining room exit, in the overhang, was missing an escutcheon and did not completely cover the hole around the sprinkler. And (2) in the main dining room area, on the second tier of the ceiling, 1 sprinkler head was missing an escutcheon, and did not completely cover the hole around the sprinkler. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m. 3.1-19(b)	K 0351	**K 351** 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? No residents were affected by this alleged deficiency. Sprinkler company contacted to install missing escutcheons. 2. How will other residents having the same potential to be affected by the alleged deficient practice be identified and what corrective action will be taken? An audit was completed of all mounted sprinklers inside/outside of the building to ensure compliance. No other missing escutcheons were found. Maintenance has been educated on appropriate inspection of mounted fire sprinklers. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? Escutcheons will be replaced accordingly. No other missing escutcheons were found. Maintenance has been educated on appropriate inspection of mounted fire sprinklers. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? The Maintenance Supervisor and/or Designee will ensure that sprinklers are inspected monthly.	09/12/2022

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			Maintenance Supervisor and will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached. 5. By what date will systemic changes be completed? 9/12/2022	
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 record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection	K 0353	K353 It is the facility policy to ensure the following: sprinkler system/sprinkler heads are inspected and maintained monthly, free of debris, the gauge and valve checks on the facilities	09/12/2022

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	Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: During records review and interview with the Maintenance Director on 08/24/22 between 10:10 a.m. and 12:45 p.m., the Log of gauge and Valve Checks indicated gauges on the dry system for calendar year 2021 were done each week. For calendar year 2022 they were inspected on 6/17, 2/23 and 1/3 but lacked other weekly checks. The Maintenance Director stated that he previously believed the checks were needed every 6 months but will now begin checking the gauges and valves every week. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m. 2. Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, 5.2.2.2 requires		dry system are recorded weekly, and the sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? No residents were affected by this alleged deficiency. Sprinkler company contacted to inspect/fix wires and conduit on sprinkler piping. Maintenance Director has cleaned both sprinkler heads where dust was located. Maintenance Director and assistant were both educated by 9/12/2022 on weekly inspection and logging the gauge and valve checks on the facilities dry systems. 2. How will other residents having the same potential to be affected by the alleged deficient practice be identified and what corrective action will be taken? An audit was completed of all sprinklers/sprinkler piping. No other debris, wiring or conduit was found on sprinkler heads/piping in the facility. Maintenance Director/Assistant were both inserviced by 9/12/2022 on the weekly inspections and recordings of the valve and gauge checks on the facilities dry system. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged	

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	155188	A. BUILDING 01 B. WING	08/24/2022

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	sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect 24 residents in one smoke compartment. Findings include: Based on observations during a tour of the facility with the Maintenance Director 08/24/22 between 12:45 p.m. and 4:45 p.m., the service-hall attic near the entrance contained wire and conduit draped across and looped around the sprinkler pipe. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m. 3. Based on observation and interview, the facility failed to ensure sprinkler heads in the laundry area were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect 6 staff. Findings include: Based on observations during a tour of the facility with the Maintenance Director 08/24/22 between		deficient practice does not occur? Sprinkler heads and sprinkler piping will be checked monthly to ensure there are no external loads by materials resting or hanging on sprinkler piping and that all sprinkler heads are dust/debris free. 4. How will the corrective action be monitored to ensure the /alleged deficient practice will not occur? The Maintenance Supervisor and/or Designee will ensure that sprinklers/sprinkler system are inspected monthly. The Maintenance Supervisor and/or Designee will ensure that the gauge and valve checks on the facilities dry system is inspected weekly and recorded. Maintenance Supervisor will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached. 5. By what date will systemic changes be completed? 9/12/2022	

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	12:45 p.m. and 4:45 p.m., 2 of 2 sprinkler heads in the clean laundry area were covered in dust or showed signs of loading. The Maintenance Director commented that he believed they were recently cleaned. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m. 3.1-19(b)			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 30 portable fire extinguishers were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice was not in a resident care area but could affect staff in the 2nd floor attic area. Findings include:	K 0355	DEEM was working in the facility installing new AC units and their employee pulled this fire extinguisher and had it out back as a preventive measure. This fire extinguisher returned to the 2nd floor attic area the next day and was not used. DEEM had been doing some welding in the back of the facility the day Life Safety came in and pulled the extinguisher from the attic. ED and Maintenance Director spoke with DEEM about communicating when taking something	09/12/2022

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	Based on observations during a tour of the facility with the Maintenance Director 08/24/22 between 12:45 p.m. and 4:45 p.m., an ABC portable fire extinguisher mount was present in the 2nd floor attic area, near the manual pull station at the exit, but the extinguisher could not be found. The Maintenance Director stated that the extinguisher was usually there, but he was unsure where it went to, HVAC work was being done and he speculated that perhaps when they were sweating in some new connections, the installers grabbed the extinguisher to keep close but did not return it to the holder. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m. 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.			

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	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 all 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 6 staff and 25 residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director 08/24/22 between 12:45 p.m. and 4:45 p.m., the following corridor doors failed to latch positively into their respective door frames: a) Linen Storage Closet near resident room #229,	K 0363	K363 It is the policy of the facility to ensure all corridor doors have no impediment to closing and latching into the door frame and resist the passage of smoke. 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? All doors identified in alleged deficiency were fixed by the maintenance staff. A new door knob was installed on corridor door in central supply by the	09/12/2022

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	equipped with a self-closing device. b) Linen Storage Closet near resident room #329, equipped with a self-closing device. c) Linen Storage Closet near resident room #330, equipped with a self-closing device. d) Linen Storage Closet near resident room #120, equipped with a self-closing device. e) Housekeeping Closet near the Ambulance entrance, equipped with a self-closing device. f) Soiled Utility Closet on Rosewood Hall, equipped with a self-closing device. g) Shower Door on Rosewood hall. h) The Dietary corridor door in the service hall, equipped with a self-closing device. i) The "Storage" corridor door on Brookshire Hall, equipped with a self-closing device. j) Soiled Utility on Brookshire Hall, equipped with a self-closing device, had tape covering the latch on the jamb side. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m. 2. Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors would resist the passage of smoke. This deficient practice could affect 6 staff. Findings include: Based on observations during a tour of the facility with the Maintenance Director 08/24/22 between 12:45 p.m. and 4:45 p.m., the corridor door at the Central Supply Area near the ambulance entrance had a doorknob which was falling off the door, exposing a hole around the doorknob of		ambulance entrance. 2. How will other residents having the same potential to be affected by the alleged deficient practice be identified and what corrective action will be taken? No residents or visitors were affected. Maintenance Director inspected all remaining corridor doors with no issues identified. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? Maintenance and /or Designee will make rounds monthly to ensure corridor doors have no impediment to closing and latching into door frame and resisting the passage of smoke. Maintenance staff educated on corridor doors and checking to ensure they close properly into the door frame and that the doors resisting the passage of smoke. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? The Maintenance Supervisor and/or Designee will ensure that all corridor doors shut properly and resist the passage of smoke. Maintenance Supervisor will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached.	

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	approximately 2 inches which penetrated completely through the door and would not resist the passage of smoke. The Maintenance Director commented that it was on his list of things to do. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m. 3.1-19(b)		5. By what date will systemic changes be completed? 9/12/2022	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 3 of over 10 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. 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, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1)	K 0511	**K511** 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? The GFCI outlets were installed in the following areas: the pantry sink near the faucet on the TCU hall, the freestanding water machine in the Therapy Area, the Ice Machine on Brookshire Hall near the nurse's station, and by the freestanding water machine on Brookshire Hall near the nurse's station. 2. How will other residents having the same potential to be affected	09/12/2022

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	through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools.		by the alleged deficient practice be identified and what corrective action will be taken? No residents were affected by this alleged deficiency. All residents have the potential to be affected. All outlets were checked and a GFCI was installed where needed. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? Outlets as assigned through TELS are inspected annually. Maintenance Staff educated on proper electrical inspection and repair in accordance with NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? The Maintenance Supervisor and/or Designee will ensure that outlets are inspected monthly. Maintenance Supervisor and will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached. 5. By what date will systemic changes be completed? 9/12/2022	

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	NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff and up to 4 residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director 08/24/22 between 12:45 p.m. and 4:45 p.m., the following locations lacked GFCI protected outlets or evidence of the presence of a GFCI circuit; 1. The Pantry sink near the faucet on the TCU Hall. 2. The freestanding water machine in the Therapy Area. 3. The Ice Machine on Brookshire Hall near the nurse's station. 4. The freestanding water machine on Brookshire Hall near the nurse's station. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m. 3.1-19(b)			
K 0712 SS=C 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			

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	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 1. Based on record review and interview, the facility failed to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: During records review and interview with the Maintenance Director on 08/24/22 between 10:10 a.m. and 12:45 p.m., 5 of 9 quarterly fire drills were conducted near the end of the month, between the 28th and 31st day of the month. These conditions do not allow fire drills to be conducted at unexpected times. Furthermore, the times of the fire drills were the same for each shift during each quarter, 11 a.m. for the first shift, 7 p.m. for the third shift and 5 p.m. for the second shift. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m. 2. Based on record review and interview, the facility failed to conduct fire drills or documented orientation training on each shift for 4 quarter of 2021. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance	K 0712	**K712** **It is the policy of the facility to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions.** **1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice?** **The maintenance director will conduct fire drills quarterly on each shift.** **The Administrator/designee will audit all new employee files for documented orientation training.** **2. How will other residents having the same potential to be affected by the alleged deficient practice be identified and what corrective action will be taken?** **This deficient practice could affect all residents, staff and**	09/12/2022

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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 patients. Findings include: During records review and interview with the Maintenance Director on 08/24/22 between 10:10 a.m. and 12:45 p.m., all shifts during the fourth quarter were missing documentation of a completed fire drill or documented orientation training. The Maintenance Director stated that was before his time began at the facility and he was unsure what happened. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m. 3.1-19(b) 3.1-51(c)		**visitors in the facility. Maintenance staff will perform routine fire drills at unexpected times on each shift.** **3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur?** **Administrator and Maintenance staff was educated on conducting fire drills/completion on fire drills on unexpected days and times. Administrator will audit fire drill records monthly for 6 months.** **4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur?** **The Maintenance Supervisor and/or Designee will ensure fire drills are completed monthly on each shift per policy at different times and recorded appropriately via TELS system. Maintenance Supervisor will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been**	

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			reached. **5. By what date will systemic changes be completed?** **9/12/2022**	
K 0761 SS=F Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 10 of 12 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame.	K 0761	**K761** 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? The annual inspection was completed for the remaining 10 of 12 fire doors. 2. How will other residents having the same potential to be affected by the alleged deficient practice be identified and what corrective action will be taken? No residents or visitors were affected. An annual fire door inspection was completed on the remaining fire doors and documented in TELS. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? Fire doors are to be inspected annually and documented in TELS. Maintenance director and assistant have been educated on timeliness of inspecting the fire doors and completing items timely	09/12/2022

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	155188	A. BUILDING 01 B. WING	08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENFIELD HEALTHCARE CENTER	200 GREEN MEADOWS DR GREENFIELD, IN 46140

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	(2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include: During records review and interview with the Maintenance Director on 08/24/22 between 10:10 a.m. and 12:45 p.m., no documentation of an annual inspection for 10 of the 12 fire door assemblies was available for review. Annual Inspection Documentation for two door assemblies (Brookshire Center Hall, and the Activities Area) was available for review, all other doors assemblies were missing inspection documentation. The Maintenance Director stated he had not done an annual door inspection since he began at the facility in January of 2022.		via the TELS system. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? The Maintenance Supervisor and/or Designee will ensure that doors are inspected and issues documented accordingly monthly. Maintenance Supervisor will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached. 5. By what date will systemic changes be completed? 9/12/2022	

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	This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m. 3.1-19(b)			
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	K 0914	**K914** **It is the policy of this facility to ensure testing and**	09/12/2022

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	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 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: During records review and interview with the Maintenance Director on 08/24/22 between 10:10 a.m. and 12:45 p.m., an itemized listing of inspection and testing electrical outlet receptacles within the most recent twelve-month period was not available for review. Likewise, no documentation was available for review itemizing electrical receptacle testing prior to January 2020 and the beginning of the COVID 19 Pandemic. Based on observations with the Maintenance		**documentation of electrical outlet receptacle testing is completed annually at all resident rooms.** **1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice?** **The maintenance director will ensure all electrical outlet receptacles in resident rooms are tested within a 12 month period.** **2. How will other residents having the same potential to be affected by the alleged deficient practice be identified and what corrective action will be taken?** **All residents have the potential to be affected. Maintenance staff to complete receptacle testing in all resident rooms.** **3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur?** **The Executive Director will audit 6 tests results a month for 12 months. Maintenance staff educated on completion of**	

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	Director during a tour of the facility each resident sleeping room had multiple electrical receptacles installed near resident bed locations. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m. 3.1-19(b)		**receptacle testing in residents rooms annually. Task reminder via TELS to ensure receptacle testing is completed.** **4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur?** **The Maintenance Supervisor and/or Designee will ensure all outlets in residents rooms are tested annually. Maintenance staff will complete testing in 10 rooms a week until compliance is met. Maintenance Supervisor will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached.** 5. **By what date will systemic changes be completed?** **9/12/2022**	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords			

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	Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 2 of 2 power cord daisy chains were not used as and as a substitute for fixed wiring. 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. Article 400.8 (1) prohibits daisy chains, because the first extension cord (or power strip) is now acting as a substitute for the fixed wiring of a structure. This deficient practice could affect up to 6 staff. Findings include: Based on observations during a tour of the facility with the Maintenance Director 08/24/22 between 12:45 p.m. and 4:45 p.m., in the Physicians Lounge	K 0920	**K920** 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? The maintenance director immediately unplugged and removed the power strip that was plugged in to the other power strip from the physicians lounge. 2. How will other residents having the same potential to be affected by the alleged deficient practice be identified and what corrective action will be taken? No residents/staff or visitors were affected. The power strip was	09/12/2022

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	a power strip was plugged into another power strip. Based on interview at the time of observation, the Maintenance Director agreed the power strips were daisy chained together. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m. 3.1-19(b)		immediately removed in the physicians lounge by the Maintenance Director. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? The maintenance director will perform monthly audits to ensure this deficient practice does not occur. The facilities nurse practitioners and maintenance staff was educated on the use of power strips and not plugging a power strip into another power strip. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? The Maintenance Supervisor and/or Designee will perform monthly rounds to ensure compliance is met with power strips and issues documented accordingly. Maintenance Supervisor will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached. 5. By what date will systemic changes be completed? 9/12/2022	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to			

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	another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 2 oxygen storage rooms where oxygen transferring takes place, was provided with properly working mechanical ventilation. NFPA 99 2012 edition, 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical exhaust to maintain a negative pressure in the space continuously. This deficient practice could affect up to 15 residents in one smoke compartment. Findings include: Based on observations during a tour of the facility with the Maintenance Director 08/24/22 between 12:45 p.m. and 4:45 p.m., the oxygen storage/transfer room on Rosebud Hall contained large liquid oxygen tanks. The room did have a mechanically ventilated exhaust fan, but it did not appear to be working. No fan noise could be detected, and when paper was held near the vent opening, no evidence of suction could be observed. The Maintenance Director stated that the fan did not appear to be working or at least was not pulling air out of the room sufficient enough to be noticeable.	K 0927	**K927** **It is the policy of the facility to ensure there is properly working mechanical ventilation** where oxygen transferring takes place. **1.** What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice. **The maintenance director installed a new exhaust fan in the oxygen transfilling room on Rosewood.** **2.** How will other residents having the same potential to be affected by the alleged deficient practice be identified and what corrective action will be taken? **No residents were affected by this alleged deficiency. Maintenance director installed a new working exhaust fan in the oxygen transfilling room on Rosewood.** **3.** What measures will be put into place or systemic changes will be made to ensure that the alleged	09/12/2022

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	This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m. 3.1-19(b)		deficient practice does not occur? **All other oxygen rooms in the facility were checked with no findings. The maintenance director/designee will perform monthly rounds as part of the preventive maintenance program to ensure the oxygen transfilling rooms have working mechanical ventilation. Maintenance staff was educated on ventilation in the oxygen transfilling rooms.** **4.** How will the corrective action be monitored to ensure the alleged deficient practice will not occur? The Maintenance Supervisor and/or Designee will ensure that all oxygen transfilling rooms have proper working mechanical ventilation. Maintenance Supervisor will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached. 5. By what date will systemic changes be completed? 9/12/2022	