| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | 155076 | A. BUILDING -- B. WING | 12/22/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| BRICKYARD HEALTHCARE - BROOKVIEW CARE CENTER | 7145 E 21ST STREET INDIANAPOLIS, IN 46219 |

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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date(s): 12/21/23 & 12/22/23<br><br>Facility Number: 000031<br>Provider Number: 155076<br>AIM Number: 100266150<br><br>At this Emergency Preparedness survey, Brickyard Healthcare -Brookview Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.<br><br>The facility has 136 certified beds. At the time of the survey, the census was 65.<br><br>Quality Review completed on 01/02/24 | E 0000 | Preparation, submission and implementation of the Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth in the survey report. Our Plan of Correction was prepared and executed as a means to continuously improve the quality of care and comply with all applicable federal and state requirements.<br>="" p="">="" p="">="" p="">="" p="">="" p="">="" p="">="" p="">="" p="">The facility respectfully requests a desk review of our responses to this survey. | |
| K 0000<br><br>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).<br><br>Survey Date(s): 12/21/23 & 12/22/23<br><br>Facility Number: 000031<br>Provider Number: 155076<br>AIM Number: 100266150 | K 0000 | Preparation, submission and implementation of the Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth in the survey report. Our Plan of Correction was prepared and executed as a means to continuously improve the quality of care and comply with all applicable federal and state | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Keary Dye | Transitional ED | 01/12/2024 |

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| | At this Life Safety Code survey, Brickyard Healthcare-Brookview Care 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.<br><br>This facility, with the east and west wing consisting of one story and the subacute wing consisting of two stories and a basement, was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. All resident sleeping rooms were surveyed. The facility has a capacity of 136 and had a census of 65 at the time of this visit.<br><br>All areas where residents have customary access were sprinklered. The facility has one detached shed providing facility storage services which was not sprinklered.<br><br>Quality Review completed on 01/02/24 | | requirements.<br>="" p=""><br>="" p=""><br>="" p=""><br>="" p=""><br>="" p=""><br>="" p=""><br>="" p=""><br>The facility respectfully requests a desk review of our responses to this survey. | |
| K 0222<br>SS=E<br>Bldg. 01 | NFPA 101<br>Egress Doors<br>Egress Doors<br>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:<br>CLINICAL NEEDS OR SECURITY THREAT LOCKING<br>Where special locking arrangements for the clinical security needs of the patient are | | | |

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| | 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.<br>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6<br>SPECIAL NEEDS LOCKING ARRANGEMENTS<br>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.<br>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4<br>DELAYED-EGRESS LOCKING ARRANGEMENTS<br>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.<br>18.2.2.2.4, 19.2.2.2.4<br>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS<br>Access-Controlled Egress Door assemblies | | | |

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| | installed in accordance with 7.2.1.6.2 shall be permitted.<br>18.2.2.2.4, 19.2.2.2.4<br>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS<br>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.<br>18.2.2.2.4, 19.2.2.2.4 | | | |
| | 1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 6 delayed egress locks were readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided:<br>(a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6.<br>(b) The doors unlock upon loss of power controlling the lock or locking mechanism.<br>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be | K 0222 | 1. The generator exit between 200 and 300 wings was fitted with delayed egress signs and the code was posted on the keypad at the entrance to the reflections unit.<br>2. All residents in the area have the potential to be affected by this alleged deficient practice.<br>3. A weekly task was placed in TELS to check delayed egress and delayed egress signage weekly. A monthly task was placed in TELS to check the exists with no delayed egress for the posting of codes including ensuring the entrance door had to be posted.<br>4 The maintenance Director or designee will report the findings to the QAPI committee at least on a quarterly basis.<br>5. The date of completion is January 5, 2024 | 01/05/2024 |

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| | continuously applied for more than 3 seconds.<br>The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.<br>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.<br>(d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads:<br>"PUSH UNTIL ALARM SOUNDS.<br>DOOR CAN BE OPENED IN 15 SECONDS".<br>This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility.<br><br>Findings include:<br><br>Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 8:35 a.m. to 11:10 a.m. on 12/22/23, the exit door set to the outside of the facility in the walkway between the 200 Hall and the 300 Hall was marked as a facility exit with an exit sign. The door set could be opened by entering the posted code at the keypad at the exit door set. The exit door set was also a delayed egress door set but it was not posted with the necessary signage. The exit door set released to open after pushing for 15 seconds when tested to open multiple times. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned exit door set was not provided with the necessary delayed egress signage. | | | |

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| | These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference.<br><br>3.1-19(b)<br><br>2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 9 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility by the main dining room.<br><br>Findings include:<br><br>Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 8:35 a.m. to 11:10 a.m. on 12/22/23, the exit door set from the main dining room into the 100 Hall by Room 111 was marked as a facility exit with an exit sign. The exit door set could be opened by entering a four digit code into a keypad at the exit door set but the code was not posted to release the door set to open. Based on interview at the time of the observations, the Executive Director stated all residents in the 100 Hall need to be in a secure wing but agreed the code to release the exit door set from the main dining room into the 100 Hall to open was not posted at the exit door set.<br><br>These findings were reviewed with the Executive Director and the Maintenance Director during the | | | |

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| | exit conference.<br><br>3.1-19(b) | | | |
| K 0281<br>SS=E<br>Bldg. 01 | NFPA 101<br>Illumination of Means of Egress<br>Illumination of Means of Egress<br>Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention.<br>18.2.8, 19.2.8<br>1. Based on observation and interview, the facility failed to ensure continuity of egress lighting for 1 of 9 exits. For the purposes of this requirement, exit access shall include only designated stairs, aisle, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways and exit passageways leading to a public way. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility by Room 302.<br><br>Finding include:<br><br>Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 8:35 a.m. to 11:10 a.m. on 12/22/23, the exit discharge for the exit on the northeast side of the facility by Room 302 did not have egress lighting from the exit to the public way. The exit door was marked as a facility exit with an exit sign. Based on interview at the time of the observations, the Maintenance Director agreed the exit discharge for the northeast exit of the facility by Room 302 did not have egress lighting from the exit to the public way. | K 0281 | 1. A double light fixture was added to the exit closest to room 302 and the double light fixture was repaired outside the exit nearest room 200.<br>2. More than 20 residents, staff and visitors have the potential to be affected.<br>3. A monthly tasks has been added to TELS to check all double exterior light fixtures near exits to ensure proper illumination with both bulbs working.<br>4. Maintenance Director or designee will report to the QAPI committee at least on a quarterly basis.<br>5. The date of completion is January 5, 2024. | 01/05/2024 |

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These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference.

3.1-19(b)

2. Based on observation and interview, the facility failed to ensure egress lighting for 1 of 9 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect over 20 residents, staff and visitors in the facility if needing to exit the facility.

Findings include:

Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 8:35 a.m. to 11:10 a.m. on 12/22/23, the exit discharge for the 200 Hall by Room 200 was equipped with two separate light bulbs but one of the two light bulbs was burnt out. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned exit discharge was not equipped with the minimum number of operable lighting fixtures.

These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference.

3.1-19(b)

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| K 0324<br>SS=D<br>Bldg. 01 | NFPA 101<br>Cooking Facilities<br>Cooking Facilities<br>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* 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<br>* 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<br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.<br>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.<br>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<br>Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be | K 0324 | 1. The kitchen hood was cleaned by Hoodz on December 23, 2023.<br>2. All residents in the area have the potential to be affected.<br>3. Safe Care was contacted to ensure Hoodz is on schedule to clean the kitchen hood every 6 months. The next service will be done in June 2024.<br>4. A task has been scheduled in TELS to have hood professionally cleaned by an outside contractor every 6 months with the next service to be done in June 2024.<br>The maintenance director or | 12/23/2023 |

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| | contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect all kitchen staff.<br><br>Findings include:<br><br>Based on review of the kitchen range hood inspection contractor's "Job Service Report" documentation dated 07/28/22 and 06/06/23 with the Executive Director and and the Maintenance Director during record review from 9:15 a.m. to 2:45 p.m. on 12/21/23, documentation of a kitchen exhaust system inspection six months after 07/28/22 was not available for review. Based on interview at the time of record review, the Maintenance Director stated the facility has switched kitchen range hood inspection contractor's after 07/28/22 and agreed documentation of a kitchen exhaust system inspection six months after 07/28/23 was not available for review.<br><br>These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. | | designee will report in the QAPI meeting at least quarterly.<br>5. The date of completion was 12/23/23 | |

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| | 3.1-19(b) | | | |
| K 0353 SS=E Bldg. 01 | NFPA 101<br>Sprinkler System - Maintenance and Testing<br>Sprinkler System - Maintenance and Testing<br>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.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>Based on observation and interview, the facility failed to maintain the ceiling construction for 1 of 2 ceilings. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect over 20 residents, staff and visitors.<br><br>Findings include: | K 0353 | 1.The gap in the attic accesses closets near rooms 105 and 109 were repaired to allow for proper operation of the sprinkler heads by closing the gap to the attic.<br>2. All residents in the area have potential to be affected by this alleged deficient practice.<br>3. A monthly attic access check to ensure proper operation of sprinkler systems was added to TELS.<br>4. The maintenance director or designee will report to the QAPI committee at least on a quarterly basis. | 01/05/2024 |

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| BRICKYARD HEALTHCARE - BROOKVIEW CARE CENTER | 7145 E 21ST STREET<br>INDIANAPOLIS, IN 46219 |

| (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 |
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| | Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 8:35 a.m. to 11:10 a.m. on 12/22/23, a twenty inch long by 1 inch wide gap was noted in between the attic access door and the opening for the access door in the ceiling of the soiled utility room by Room 105. A similar gap was noted in between the attic access door and the opening for the access door in the ceiling of the Telephone Room by Room 209. The gaps exposed the attic above. Each room was equipped with one pendant sprinkler installed on the ceiling. Based on interview at the time of the observations, the Maintenance Director agreed the openings in the ceiling would delay activation of the sprinkler installed in the room.<br><br>These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | | 5. The date of completion was January 5, 2024. | |
| K 0355 SS=E Bldg. 01 | NFPA 101<br>Portable Fire Extinguishers<br>Portable Fire Extinguishers<br>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.<br>18.3.5.12, 19.3.5.12, NFPA 10<br>Based on observation and interview, the facility failed to ensure 2 of 21 portable fire extinguishers were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, the | K 0355 | 1. The fire extinguishers throughout the facility were audited to ensure current sign offs were present and a list of all extinguishers was made to ensure locations are known.<br>2. All residents in the area of the beauty shop and kitchen door door area by 100 hall had the potential | 01/05/2024 |

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| | 155076 | A. BUILDING 01<br>B. WING | 12/22/2023 |

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| | Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect over 20 residents, staff and visitors.<br><br>Findings include:<br><br>Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 8:35 a.m. to 11:10 a.m. on 12/22/23, the affixed maintenance tag for the following ABC type portable fire extinguisher locations had missing monthly inspection documentation:<br>a. in the Salon for April & May 2023.<br>b. in the kitchen exit area to the 100 Hall for April 2023.<br>The portable fire extinguisher inspection contractor indicated on the affixed maintenance tag the annual inspection and maintenance for each of the two fire extinguishers was performed in March 2023. Based on interview at the time of the observations, the Maintenance Director stated the Salon has been closed due to Covid-19 and agreed the aforementioned portable fire extinguisher locations each had missing monthly inspection documentation. | | to be affected.<br>3. A task was placed in TELS to inspect and sign off on all fire extinguishers monthly.<br>4. The maintenance director or designee will report to the QAPI committee at least on a quarterly basis.<br>5. The date of compliance was January 5, 2024 | |

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| | These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | | | |
| K 0712<br>SS=F<br>Bldg. 01 | NFPA 101<br>Fire Drills<br>Fire Drills<br>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.<br>19.7.1.4 through 19.7.1.7<br>Based on record review and interview, the facility failed to provide documentation of a fire drill conducted on the second shift for 1 of 4 quarters. This deficient practice affects all residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of Direct Supply TELS Logbook Documentation "Fire Drills" documentation, "Fire Drill Record" documentation and "Fire Drill Report" documentation with the Executive Director and and the Maintenance Director during record review from 9:15 a.m. to 2:45 p.m. on 12/21/23, documentation of a fire drill conducted on the second shift in the first quarter (January, February, March) 2023 was not available for review. Based on interview at the time of record | K 0712 | 1. The missing fire drill for the first quarter second shift were not recovered. All drills since have been conducted as per the regulation.<br>2. All residents have the potential to be affected.<br>3. The TELS system was implemented in July and a task was included for each quarter and each shift for compliance with once per shift per quarter standard correcting the issue and ongoing monitoring as all drills must be uploaded to close the task.<br>4. The maintenance director of designee will report to the QAPI committee at least on a quarterly | 12/22/2023 |

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| | review, the Executive Director and the Maintenance Director stated the facility operates three shifts per day and agreed documentation of a fire drill conducted on the second shift in the first quarter 2023 was not available for review.<br><br>These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference.<br><br>3.1-19(b) and 3.1-51(c) | | basis.<br>5. The date of completion is December 22, 2023. | |
| K 0761 SS=F Bldg. 01 | Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all 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. | K 0761 | 1. The o2 room door was added to the list of fire doors on the annual fire door inspection and was re-inspected and documented on paper.<br>2. All the residents in the area of the o2 room have the potential to be affected.<br>3. An annual fire door inspection was placed in TELS and a location log was sent to add the o2 room location to the task to prevent recurrence.<br>4. The maintenance director or designee will report to the QAPI committee at least on a quarterly basis.<br>5. The date of completion is January 5, 2024. | 01/05/2024 |

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| | NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified:<br>(1) No open holes or breaks exist in surfaces of either the door or frame.<br>(2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.<br>(3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.<br>(4) No parts are missing or broken.<br>(5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.<br>(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.<br>(7) If a coordinator is installed, the inactive leaf closes before the active leaf.<br>(8) Latching hardware operates and secures the door when it is in the closed position.<br>(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.<br>(10) No field modifications to the door assembly have been performed that void the label.<br>(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity.<br>This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of Direct Supply TELS "Inspection-Latch and Gap" documentation with the Executive Director and and the Maintenance Director during record review from 9:15 a.m. to 2:45 p.m. on 12/21/23, it was unclear which fire doors were inspected and tested in the facility and when they were inspected and tested. Based on | | | |

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| | observations with the Executive Director and the Maintenance Director during a tour of the facility from 8:35 a.m. to 11:10 a.m. on 12/22/23, the oxygen storage and transfilling room near the east nurse's station had a total of eleven oxygen containers and four 'E' type oxygen cylinders stored in the room. A 90-minute fire resistance rating label was affixed to the hinge side of the corridor door to the room. Based on review of Direct Supply TELS Logbbook Documentation "Fire Doors Inspection-Latch & Gap" documentation dated 10/20/23 during the exit conference from 11:10 a.m. to 12:00 p.m. on 12/22/23, the door to the oxygen storage room was not specifically listed on the 10/20/23 inspection documentation and it was unclear if all fire doors in the facility were included in the 10/20/23 annual fire door inspection and testing documentation. Based on interview at the time of the exit conference, the Maintenance Director stated the facility was in the process of changing how they document inspections and testing from Building Engines to Direct Supply TELS Logbook Documentation and agreed it was unclear if the 10/20/23 annual fire door inspection and testing documentation included all fire doors in the facility.<br><br>These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | | | |
| K 0920 SS=E Bldg. 01 | NFPA 101<br>Electrical Equipment - Power Cords and Extens<br>Electrical Equipment - Power Cords and Extension Cords<br>Power strips in a patient care vicinity are only | | | |

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| | 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<br>Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care | K 0920 | 1. Room 105 power strip was removed and a hospital grade power strip UL60601 was ordered and installed. All residents rooms were audited to ensure no unapproved PCREE was present.<br>2. The residents in the adjacent area to room 105 had the potential to be affected.<br>3. A quarterly inspection was added to the TELS program which includes checking for unapproved PCREE. 1/3 of the facility will be inspected in January, 1/3 of the facility will be inspected in February and 1/3 of the facility will be inspected in March continuing on a rotation in perpetuity. | 01/10/2024 |

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| | vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over twenty residents, staff and visitors in the vicinity of resident sleeping Room 105.<br><br>Findings include:<br><br>Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 8:35 a.m. to 11:10 a.m. on 12/22/23, the resident bed and a headphone cable were plugged into a power strip dangling from the wall within three feet of the resident bed nearest the corridor door to resident sleeping Room 105. The UL listing of the power strip could not be determined. Based on interview at the time of the observations, the Maintenance Director agreed a power strip was being used in the patient care vicinity for PCREE and non-PCREE and as a substitute for fixed wiring at the aforementioned location in the facility.<br><br>These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | | 4. The maintenance director of designee will report to the QAPI at least on a quarterly basis.<br>5. The date of completion is January 10, 2024 | |