STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E667	A. BUILDING -- B. WING	05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNHURST HEALTHCARE	5225 W MORRIS ST INDIANAPOLIS, IN 46241

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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: 05/26/21 Facility Number: 000385 Provider Number: 15E667 AIM Number: 100291340 At this Emergency Preparedness survey, Lynhurst Healthcare was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 40 certified beds. At the time of the survey, the census was 37. Quality Review completed on 06/04/21 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2),			

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

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	§483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must			

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	develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based, and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). In the Survey & Certification memo QSO: 19-06-ALL dated 02/01/19, the Centers for Medicare and Medicaid Services (CMS) updated Appendix Z of the State Operations Manual to reflect changes to add emerging infectious diseases to the	E 0006	A plan was located for EID which will be forwarded. All residents could be affected. A complete review of the Emergency Preparedness Manual will have all policies which address a community based risk assessment including EID Monthly a section of this manual will be reviewed with QAPI and training to all staff. There is a section on Emergency	06/21/2021

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	definition of all-hazards approach and stated "Planning for using an all-hazards approach should also include emerging infectious disease (EID) threats. Examples of EIDs include Influenza, Ebola, Zika Virus and others". This deficient practice could affect all occupants. Findings include: Based on review of the facility's "Emergency Preparedness Plan" dated 08/26/20 with the Administrator and the Maintenance Director during record review from 9:10 a.m. to 12:25 p.m. on 05/26/21, a documented facility-based and community-based risk assessment addressing emerging infectious disease (EID) threats was not available for review. EID was not included in the current "Hazard Risk Assessment" for the facility. Based on interview at the time of record review, the Administrator agreed emergency preparedness program documentation did not address emerging infectious diseases as part of the facility-based and community-based risk assessment as mandated by the CMS Survey & Certification memo QSO: 19-06-ALL. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference.		Situations in our New employee packet which will be forwarded. Administrator responsible and will monitor.	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b),			

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	§485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies,			

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	including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update its emergency preparedness policies and procedures to include policies and procedures for emerging infectious diseases (EID). The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all occupants. Findings include: Based on review of the facility's "Emergency Preparedness Plan" dated 08/26/20 with the Administrator and the Maintenance Director during record review from 9:10 a.m. to 12:25 p.m. on 05/26/21, emergency preparedness	E 0013	See E0006	06/21/2021

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	policies and procedures for emerging infectious diseases (EID) was not available for review. EID was not included in the current "Hazard Risk Assessment" for the facility. Based on interview at the time of record review, the Administrator agreed emergency preparedness program policies and procedures did not include EID as part of the facility-based and community-based risk assessment as mandated by the CMS Survey & Certification memo QSO: 19-06-ALL. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference.			
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.			

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	(ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness			

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	policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and			

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	existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires,			

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	protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the	E 0037	**E 037 Emergency Plan Training Program** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** The Emergency Plan has been modified based on the findings from the recent Survey. All	06/30/2021

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	training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d)(1). This deficient practice could affect all occupants. Findings include: Based on review of the facility's "Emergency Preparedness Plan" dated 08/26/20 with the Administrator and the Maintenance Director during record review from 9:10 a.m. to 12:25 p.m. on 05/26/21, documentation for staff training on emergency preparedness within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Administrator and Maintenance Director stated staff is regularly trained on specific emergency preparedness policies but agreed staff training on all emergency preparedness program documentation within the most recent twelve month period was not available for review at the time of the survey. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference.		employees have been in-serviced on the Emergency Plan. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected by this deficient practice. The Emergency Preparedness Plan has been reviewed to ensure the Plan has the correct information. This will be reviewed no less then annually. Existing employees have been in-serviced and all new employees will be in-serviced at time of hire. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Emergency Plan Emergency Contact has been modified based on the new information received during recent Survey. All staff have been in-serviced on the Emergency Plan. This and will become a part of Lynhurst Healthcare “New Hire Packet” for employees. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** The Administrator (or designee) will submit a report to the QAPI Committee monthly, beginning in July 2021, for a period of six	

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			months that certifies that the Policy & Procedures remain accurate and adequate. **Completion date:** 06/30/21	
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: 05/26/21 Facility Number: 000385 Provider Number: 15E667 AIM Number: 100291340 At this Life Safety Code survey, Lynhurst Healthcare was found not in compliance with Requirements for Participation in 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 facility, constructed in two sections, is fully sprinklered. The oldest section, a former two story private residence with a basement and the newer section, a one story addition were both determined to be of Type V (111) construction. 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 installed in all resident sleeping rooms. All resident sleeping rooms were surveyed. The facility has a capacity of 40 and had a census of 37 at the time of this visit.	K 0000	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Superior Systems our Fire System company will be out to install sprinklers in the two areas cited. This will be done by June 30th, 2021. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** While this does not represent a potential to harm our residents, it is vital we do as code requires. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice** does **not recur:** Urgent follow thru when citing's are made from SBOH or Life Safety. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** Respond to citations from entities	

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LYNHURST HEALTHCARE	5225 W MORRIS ST INDIANAPOLIS, IN 46241

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	All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility services which are the laundry building and a metal storage shed which were each not sprinklered. Quality Review completed on 06/04/21		that are doing inspections immediately.	
K 0211 SS=F Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 3 of 10 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect all residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, a wheelchair weigh scale was located in the corridor outside Room 3 and projected three and one half feet into the eight foot wide corridor. Two chairs, a table and a small weigh scale were stored in the corridor outside the main Dining Room near the sliding glass door. A refrigerator was located in the path of egress outside the second floor	K 0211	**K211** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** All items that were obstructing egress have been removed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected. Therefore all items obstructing egress have been removed. Staff have been educated as to why items can not block exits. **What measures will be put into**	06/30/2021

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	restroom which restricted the path of egress to the exterior stairs to one foot in width. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned means of egress was not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**place and what systemic changes will be made to ensure that the deficient practice** does **not recur:** Rounding by Administrator or designee will occur twice a day to insure egress areas are not obstructed. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** Each day in morning meeting designee will report findings. This will occur 5 days a week for 4 weeks.2 times a week for 3 weeks and 1 time a week till compliance is met.	
K 0225 SS=E Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Based on observation and interview, the facility failed to maintain stair construction in 1 of 1 sets of stairs for 1 of 4 exit discharge. LSC Section 7.2.2.1.1 states stairs used as a component in the means of egress shall conform to the general requirements of Section 7.1 and to the special requirements of 7.2.2, unless otherwise specified in 7.2.2.1.2. Section 7.2.2.2.1.1(2) states existing stairs shall be permitted to remain in use, provided that they meet the requirements for existing stairs shown in Table 7.2.2.2.1.1(b). Section 7.2.2.2.1.1(3) states approved existing stairs shall be permitted to be rebuilt in accordance with the following:	K 0225	K225 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Exit will be out of order until repair can be made. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents could be affected by	06/30/2021

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	(a) Dimensional criteria of Table 7.2.2.2.1.1(b) (b) Other stair requirements of 7.2.2 Section 7.2.2.3.1.1 states all stairs serving as required means of egress shall be of permanent fixed construction, unless they are stairs serving seating that is designed to be repositioned in accordance with Chapters 12 and 13. This deficient practice could affect over 10 residents if needing to exit the facility using the exit discharge stairs for the northwest exit of the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, the northwest exit from the facility is marked as a facility exit with an exit sign. The exit discharge for the northwest exit consisted of a set of six steps made of concrete creating a stair. The third step in the stair was absent due to the concrete having crumbled and eroded. The last step in the exit discharge stair had a large crevice running the width of the step between the building and the handrail. Based on interview at the time of the observations, the Maintenance Director agreed stair construction was not maintained for the northwest exit discharge. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		this practice. Exit will be out of order will repaired. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice** does **not recur:** With outside rounds being done, any potential for exits being in poor repair will be noted and repaired quickly. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** Contractor has been obtained and will have stairs repaired by June 30th. Daily, maintenance will report any disrepair of exit ways.	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance			

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	with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 1. Based on observation and interview, the facility failed to ensure 1 of 1 sets of stairs for 1 of 5 exit discharge was maintained free of obstructions. LSC Section 7.7.4 states doors, stairs, ramps, corridors, exit passageways, bridges, balconies, escalators, moving walks, and other components of an exit discharge shall comply with the detailed requirements of this chapter for such components. LSC Section 7.2.2.1.1 states stairs used as a component in the means of egress shall conform to the general requirements of Section 7.1 and to the special requirements of 7.2.2, unless otherwise specified in 7.2.2.1.2. Section 7.2.2.2.1.1(2) states existing stairs shall be permitted to remain in use, provided that they meet the requirements for existing stairs shown in Table 7.2.2.2.1.1(b). Section 7.2.2.2.1.1(3) states approved existing stairs shall be permitted to be rebuilt in accordance with the following: (a) Dimensional criteria of Table 7.2.2.2.1.1(b) (b) Other stair requirements of 7.2.2 Section 7.2.2.3.1.1 states all stairs serving as required means of egress shall be of permanent fixed construction, unless they are stairs serving seating that is designed to be repositioned in accordance with Chapters 12 and 13. This deficient practice could affect over 10 residents if needing to exit the facility using the exit discharge stairs for the northwest exit of the facility. Findings include:	K 0271	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** **NW** corner exit will be out of order till repaired. All other obstructions, table in dietary exit, fridge in 2 floor area and all other obstructions will be cleared. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have a potential to be affected. Nw corner exit will be out of order till repaired. Inside all items will be moved from exit areas per rule. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice** does **not recur:** Daily outdoor and indoor rounds will identify obstructions inside and outside. Areas will be cleared upon finding obstructions. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance**	06/30/2021

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	Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, the northwest exit from the facility is marked as a facility exit with an exit sign. The exit discharge for the northwest exit consisted of a set of six steps made of concrete creating a stair. The third step in the stair was absent due to the concrete having crumbled and eroded. The last step in the exit discharge stair had a large crevice running the width of the step between the building and the handrail. Based on interview at the time of the observations, the Maintenance Director agreed the northwest exit discharge was not maintained free of obstructions. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observations and interview, the facility failed to ensure 1 of 5 exit discharge was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over two staff and visitors in the kitchen. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, the kitchen exit door to the courtyard is marked as a facility exit with an exit sign. One large round table and a chair were located in the exit discharge under the canopy blocking nearly the entire width of the		**program will be put in place:** Staff will identify exit doors being obstructed and remove items. Will report during morning meeting any deviance from policy.	

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	exit discharge. Based on interview at the time of the observations, the Maintenance Director agreed the kitchen exit discharge to the courtyard was not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0281 SS=F Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress 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. 18.2.8, 19.2.8 1. Based on observation and interview, the facility failed to ensure egress lighting for 2 of 5 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 all residents, as well as staff and visitors in the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, one of two light bulbs in the lighting fixture for the exit means of	K 0281	**K281** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** All lights have ben replaced. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents could be affected by this deficient practice. All lighting will be checked weekly to insure all egress lights are operational. **What measures will be put into**	06/30/2021

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	egress outside the main entrance was burnt out. In addition, one of two light bulbs in the lighting fixture for the exit means of egress outside the facility exit door set by Room 16 was also burnt out. Based on interview at the time of the observations, the Maintenance Director agreed light bulbs were burnt out at the two exit discharges. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure continuity of egress lighting for 1 of 5 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 2 staff and visitors if exiting the facility using the exterior stairs for the second story. Finding include: Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, the exit discharge for the second story at the exterior stairs did not have egress lighting to the public way. Based on interview at the time of the observations, the Maintenance Director agreed the exterior stairs for the second story did not have egress lighting to the public way.		**place and what systemic changes will be made to ensure that the deficient practice** does **not recur:** Weekly all egress lights will be check by Maintenance, those with batteries will be placed on a monthly preventative maintenance checklist. Any light not in operation will be changed immediately. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** The daily/weekly/monthly preventative maintenance check sheets will be performed by Maintenance. Weekly a report will be given to the Administrator and the Administrator will report Monthly to the QIAP members.	

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	This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 1. Based on observation and interview, the facility failed to ensure 1 of 6 battery powered emergency lights was maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, the battery operated lighting system outside the facility by the emergency generator location failed to illuminate when its respective test button was pushed multiple times. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned battery powered emergency light failed to illuminate when it was tested to illuminate multiple times.	K 0291	**K291** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** The battery emergency light will be replaced/or repaired by the generator. Preventative maintenance established for monthly checks of battery powered lights, to include If 30 or 90 second test was done. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected by this deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice** does	06/30/2021

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	This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review, observation, and interview; the facility failed to ensure 6 of 6 battery backup lights were tested monthly and annually during the most recent twelve month period to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of "Battery-Operated Emergency Lights - Test Log" for 2020 and 2021 with the Administrator and the Maintenance Director during record review from 9:10 a.m. to 12:25 p.m. on 05/26/21, monthly battery operated light testing documentation for January 2021 through May 2021 was not itemized by location. In addition, monthly and annual testing documentation within the most recent twelve month period did not state the duration of the test. The documentation indicated the initials of		**not recur:** Preventive maintenance protocols will be followed. Weekly report given to Administrator. Administrator will report to QAPI monthly. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** Preventative maintenance program will be followed by Maintenance Director. Reports will be made weekly to Administrator. Administrator will report to QAPI monthly.	

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	the person performing the test or a checkmark that the test was completed but it did not state the completed test was for 30 seconds or 90 minutes. Based on interview at the time of record review, the Maintenance Director agreed the battery operated light testing documentation did not state the duration of the test completed and was not itemized by location for the 2021 documentation. Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, six battery operated lighting systems were noted in the facility. Each light illuminated when its respective test button was pushed but the battery operated lighting system outside the facility by the emergency generator location failed to illuminate when its respective test button was pushed multiple times. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection 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 record review, observation, and interview; the facility failed to ensure documentation for the preventative maintenance of all battery operated smoke alarms in resident sleeping rooms was complete. NFPA 101 in	K 0300	**K300** **What corrective action will be accomplished for those residents found to have been**	06/30/2021

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	4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, 29.10 Maintenance and Tests states fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of "Battery-Operated Weekly Smoke Detector Maintenance Log" documentation with the Administrator and the Maintenance Director during record review from 9:10 a.m. to 12:25 p.m. on 05/26/21, resident room battery operated smoke detector cleaning documentation for the most recent twelve month period was not available for review. In addition, "04/21" was stated in the column to track weekly smoke detector testing for the March 2021 testing documentation. No weekly testing documentation for March 2021 was available for review. Based on interview at the time of record review, the Maintenance Director stated she had recently started working at the facility and was unsure if the facility cleans the detectors but agreed the facility does not document cleaning. Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, manufacturer's documentation affixed to the Kidde Model i9040 battery operated smoke alarm installed on the wall above the door to Room 5 indicated weekly		**affected by the deficient practice:** Preventative maintenance established for monthly checks of battery powered lights, to include If 30 or 90 second test was done. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have a potential to be affected by this deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice** does **not recur:** Preventive maintenance protocols will be followed. Weekly report given to Administrator. Administrator will report to QAPI monthly. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** Preventative maintenance program will be followed by Maintenance Director. Reports will be made weekly to Administrator. Administrator will report to QAPI monthly.	

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	15E667	A. BUILDING 01 B. WING	05/26/2021

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	testing and annual cleaning was required. Based on interview at the time of the observations, the Maintenance Director stated each resident sleeping room contains the same type of smoke alarm. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 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			

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	gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) 1. Based on observation and interview, the facility failed to ensure 1 of over 3 hazardous areas such as boiler and fuel-fired heater rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff, and visitors in the vicinity of the Janitor's Closet by the kitchen. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, the corridor door to the Janitor's Closet was equipped with a self-closing device but the door failed to latch into the latching plate when tested to close multiple times. A natural gas fired water heater was located in the Main Mechanical Room which was open to the Janitor's Closet. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned hazardous area were not separated from other spaces by smoke resistant partitions and doors. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0321	**K321** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** A fire/smoke resistance barrier will be constructed between the boiler and janitors closet. The door will be repaired with other doors not meeting code. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected by this deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice** does **not recur:** Anytime a space is going to be assigned a dual function, the Administrator must be notified to ensure we are making wise decisions, regarding fire prevention. Monthly the maintenance woman will inspect each door to insure a tight	06/30/2021

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	2. Based on observation and interview, the facility failed to ensure 1 of over 3 hazardous areas such as soiled linen and trash collection rooms (exceeding 64 gallons) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff, and visitors in the vicinity of the Soiled Utility Room by Room 16. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:50 p.m. to 5:35 p.m. on 05/17/21, a one inch gap was noted in between the face of the door and the door stop near the latching mechanism for the corridor door to the Soiled Utility Room by Room 16. The gap appeared to be created by gouging out the wood of the door near the latching mechanism. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned hazardous area was not separated from other spaces by smoke resistant partitions and doors. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		closure. It will be adjusted at the time of discovery **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** All decisions regarding sharing of space will be approved only by the administrator. All Departments have been advised there is to be no sharing of space without approval. All department heads are to Observe door closure and report any that do not close completely to the Administrator, in Morning Meeting.	
K 0325 SS=E Bldg. 01	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is			

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	0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485			
	Based on observation and interview, the facility failed to ensure 1 of over 2 alcohol based hand sanitizers was not installed over an ignition source. NFPA 101, in 19.1.1.3 requires all health facilities to be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect over 10 residents in the vicinity of the weigh scale in the corridor by Room 3. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, an alcohol based hand sanitizer was installed on the wall in the	K 0325	**K325** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** The ABHS outside Room 3 has been removed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents could be affected by this deficient practice. **What measures will be put into**	06/30/2021

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	corridor by Room 3 directly above a wall mounted power strip for a wheelchair weigh scale. The power strip was UL 1363A. Review of packaging materials for the hand sanitizer solution indicated it was 70% alcohol. Based on interview at the time of the observations, the Maintenance Director agreed the alcohol based hand sanitizer was installed on the wall directly above a wall mounted power strip. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**place and what systemic changes will be made to ensure that the deficient practice** does **not recur:** All new ABHS dispensers will only be placed by Maintenance. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** All new ABHS dispensers will only be placed by Maintenance. During walking rounds location of dispensers will be validated according to code. Administrator/Designee will be responsible for walking rounds. Reports made during Morning Meeting. Results reported to QAPI monthly.	
K 0341 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8			

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	Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was installed in accordance with 19.3.4.1. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, 17.5.3.1 states total smoke detector coverage shall include basements. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, the basement was not provided with fire alarm system smoke detector coverage. Battery operated smoke detectors were observed in the basement, but a fire alarm system smoke detector was not installed. Based on interview at the time of the observations, the Maintenance Director agreed the basement was not provided with fire alarm system smoke detector coverage. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0341	K341 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Superior Service Fire Suppression will in stall a hard wired smoke detector in the basement. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents could be affected by this deficient practice. Superior Fire Service is install a hard wired smoke detector in the basement. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice** does **not recur:** All recommendations from Life Safety will be taken care of immediately. All recommendations from Superior Service Fire Suppression will be taken care of immediately. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** During inspections, Superior Service Fire Suppression will make notes and recommendations. Reports reviewed by Maintenance and	06/30/2021

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			Administrator	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. Based on record review, observation, and interview; the facility failed to ensure all fire alarm system initiating devices were tested in accordance with the schedules for testing frequency in NFPA 72. LSC Section 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6 unless the provisions of 33.2.3.4.1.1 or 33.2.3.4.1.2 are met. LSC Section 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electric Code and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, Section 14.4.5 states testing shall be performed in accordance with the schedules in Table 14.4.5. Initial/Reacceptance testing shall be performed at the time of installation. Table 14.4.5 at 15(e) states the requirements of 14.4.5.5 shall apply to heat detectors. Section 14.4.5.5 states restorable fixed-temperature, spot-type heat detectors shall be tested in accordance with 14.4.5.5.1 through 14.4.5.5.4. Two or more detectors shall be tested on each initiating circuit annually. Different detectors shall be tested	K 0345	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Superior Service Fire Suppression will repair and or replace all heat detectors cited in K345. Superior Service Fire Suppression will set the annunciator panel at nurses station. They will train the Maintenance department on how to reset the clock. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected by this deficient practice. **What measures will be put into place and what systemic changes will be made to ensure**	06/30/2021

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	each year. Records shall be kept by the building owner specifying which detectors have been tested. Within 5 years, each detector shall have been tested. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Periodic Fire Alarm Inspection & Testing Report" documentation dated 06/18/20 with the Administrator and the Maintenance Director during record review from 9:10 a.m. to 12:25 p.m. on 05/26/21, nine of nine heat detectors in the facility were listed as tested. Review of the "Device Location" section of the 06/18/20 report did not list the location of any heat detectors in the facility and the results of testing. Based on interview at the time of record review, the Maintenance Director agreed the 06/18/20 fire alarm system inspection documentation did not list the location of the heat detectors which were tested and the results of the testing and stated additional heat detector testing documentation within the most recent twelve month period was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, heat detectors were installed in the Activities Room, in the corridor outside Room 3, in the stairwell to the second floor and in the basement. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the		**that the deficient practice** does **not recur:** Annunciator panel will be checked weekly and reset if necessary. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** Heat detector inspection will be added to Superior's inspection. If there is a deficiency they are directed to repair immediately. Monitored by Maintenance during inspection and reported to Administrator.	

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	facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility at 1:34 p.m. on 05/26/21, the time of day displayed for the fire alarm annunciator panel located at the nurse's station by the main entrance read 1:48 p.m. Based on interview at the time of the observations, the Maintenance Director agreed the time of day displayed for the fire alarm annunciator panel was a 14 minute time difference. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0351 SS=F Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.			

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	In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) 1. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler riser room sprinkler heads were installed in accordance with NFPA 13. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition, Section 8.6.4.1.2 states under obstructed construction, the sprinkler deflector shall be located in accordance with one of the following arrangements: (1) Installed with the deflectors within the horizontal planes of 1 in. to 6 in. (25.4 mm to 152 mm) below the structural members and a maximum distance of 22 in. (559 mm) below the ceiling/roof deck (2) Installed with the deflectors at or above the bottom of the structural member to a maximum of 22 in. (559 mm) below the ceiling/roof deck where the sprinkler is installed in conformance with 8.6.5.1.2 escutcheons used with recessed, flush-type or concealed sprinklers shall be part of a listed sprinkler assembly. (3) Installed in each bay of obstructed construction, with the deflectors located a minimum of 1 in. (25.4 mm) and a maximum of 12 in. (305 mm) below the ceiling (4) Installed with the deflectors within the	K 0351	**K351** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** All citations under K351 will be corrected by Superior Systems Fire Suppression Company. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected by this deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice** does **not recur:** The previous maintenance person did not consult anyone when trying to correct a problem;	06/30/2021

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	horizontal planes 1 in. to 6 in. (25.4 mm to 152 mm) below composite wood joists to a maximum distance of 22 in. (559 mm) below the ceiling/roof deck only where joist channels are firestopped to the full depth of the joists with material equivalent to the web construction so that individual channel areas do not exceed 300 ft 2 (27.9 m 2) (5) *Installed with deflectors of sprinklers under concrete tee construction with stems spaced less than 71.2 ft (2.3 m) but more than 3 ft (0.91 m) on centers, regardless of the depth of the tee, located at or above a horizontal plane 1 in. (25.4 mm) below the bottom of the stems of the tees and shall comply with Table 8.6.5.1.2. Section 8.6.4.2.1 states unless the requirements of 8.6.4.2.2 or 8.6.4.2.3 are met, deflectors of sprinklers shall be aligned parallel to ceilings, roofs, or the incline of stairs. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, the deflector for the upright sprinkler mounted in the sprinkler riser room was imbedded in insulation which had dropped down from the underside of the roof for the room. Based on interview at the time of the observations, the Maintenance Director agreed the sprinkler deflector was imbedded in the insulation. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		therefore, we have a lot of code violations. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** The current maintenance team have knowledge of fire codes and will seek assistance when unsure. Superior Systems Fire Suppression Company will look at all aspects of Fire Safety during their inspections and will notify Maintenance and the Administrator.	

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	2. Based on observation and interview, the facility failed to maintain the canopy construction in 1 of 3 exterior canopies. 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 10 residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, a two inch in diameter hole was noted in the exterior canopy outside the exit door set by Room 15 across from the Soiled Utility Room. Based on interview at the time of the observations, the Maintenance Director agreed there was a hole on the underside of the canopy outside the exit door set from across from the Soiled Utility Room. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 2 of over 25 sprinkler heads in the facility were installed in accordance with NFPA 13. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition,			

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	Section 6.2.7.2 states escutcheons used with recessed, flush-type or concealed sprinklers shall be part of a listed sprinkler assembly. Section 6.2.7.3 states cover plates used with concealed sprinklers shall be part of the listed sprinkler assembly. This deficient practice could affect over 10 residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, the ceiling mounted sprinkler in the exterior canopy by Room 15 and in the exterior canopy for the kitchen exit to the courtyard were each missing its escutcheon. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned sprinkler locations were missing an escutcheon. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____			

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	b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler systems 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 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 all residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, the following was noted: a. a gray data cable and one gray flexible HVAC ductwork were resting on horizontal sprinkler piping in one of the third floor support rooms. b. a second gray flexible ductwork was affixed to horizontal sprinkler piping with gray duct tape in a second third floor support room. c. a yellow data cable was resting on horizontal sprinkler piping at the nurse's station near the main entrance. Based on interview at the time of the observations, the Maintenance Director agreed sprinkler piping was used to support nonsystem	K 0353	**K353** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Not available at the time of inspection we have had quarterly inspections from Superior. See documents. Superior will fix the 3rd floor sprinkler impairment and the yellow cable at the Nurses station. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected by this deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice** does **not recur:** Maintenance will maintain a log of inspections and due dates to ensure these copies are kept and available for Life Safety. **How the corrective action will**	06/30/2021

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	components at the aforementioned locations. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** Monthly Maintenance will report what inspections are due or completed for the month during the QAPI meeting. Maintenance responsible and Administrator to monitor.	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed for the protection of all residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25. NFPA 25, Standard for the Inspection, Testing and	K 0354	**K354** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** System down policy, including Fire Watch instructions has been located and put in the policy and procedure manual.	06/30/2021

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	Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 15.5.2 requires nine procedures that the impairment coordinator shall follow. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of "Fire Alarm System Impairments" documentation with the Administrator and the Maintenance Director during record review from 9:10 a.m. to 12:25 p.m. on 05/26/21, the fire watch policy did not expressly state the policy for sprinkler system impairment. The aforementioned documentation addressed "fire alarm systems" impairment but did not state if the sprinkler system was part of the facility's "fire alarm systems". Based on interview at the time of record review, the Maintenance Director agreed the fire watch policy did not expressly state the policy for sprinkler system impairment. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected by this deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice** does **not recur:** Our emergency plan has been reviewed and updated to include missing policies. Monthly we will train staff on one segment of the plan. Updated binders will be present in all departments. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** Monthly during QAPI one segment will be reviewed along with any updated policies. Maintenance to provide and Administrator or designee to monitor.	
K 0362 SS=E Bldg. 01	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In			

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	nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7			
	Based on observation and interview, the facility failed to ensure corridor walls for 1 of 1 main Dining Rooms was constructed to resist the passage of smoke. This deficient practice could affect over 10 residents, staff, and visitors in the main Dining Room. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, the corridor door to the Nutrition Room in the main Dining Room had a three foot by one foot grill installed in the door near the floor. The main Dining Room was open to the corridor. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned opening in the corridor wall would not resist the passage of smoke. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference.	K 0362	**K362** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Door will be repaired or replaced to rid the wire mesh portion of the door. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected by this deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice** does **not recur:** Previous Maintenance did not	06/30/2021

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	3.1-19(b)		seek advice when correcting problems. All maintenance problems will be approved by the Administrator to ensure codes are followed. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** Supervision of projects by the Administrator, new maintenance team that are aware of codes and requirements. Maintenance responsible and Administrator to monitor. Reviewed monthly during QAPI.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping			

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	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. Based on observation and interview, the facility failed to ensure 6 of over 25 corridor doors had no impediment to closing and latching into the door frame or would resist the passage of smoke. This deficient practice could affect over 10 residents, staff, and visitors near the kitchen. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, the following was noted: a. a one inch gap was noted in between the face of the door and the door stop near the top of the corridor door to Room 1. b. a one inch gap was noted in between the face of the door and the door stop near the top of the corridor door to Room 12.	K 0363	**K363** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** All six doors identified will be repaired or replaced. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents could be affected by this deficient practice. **What measures will be put into place and what systemic changes will be made to ensure**	06/30/2021

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	c. a one inch gap was noted in between the face of the door and the door stop near the latching mechanism for the corridor door to the Soiled Utility Room by Room 16. The gap appeared to be created by gouging out the wood near the latching mechanism. d. the corridor door to the Janitor's Closet was equipped with a self-closing device but the door failed to latch into the latching plate when tested to close multiple times. e. the corridor door to the Activities Room by the interior stairwell on the first floor would not latch into the door frame because the top of the door kept hitting the top of the door frame when tested to close multiple times. f. the corridor door to the kitchen by the Janitor's Closet was equipped with a thumb twist lock and was not equipped with a positive latching device. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned corridor doors had an impediment to closing and latching into the door frame or would not resist the passage of smoke. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**that the deficient practice** does **not recur:** Monthly during rounds by maintenance each door will be closed to ensure doors are operating correctly. doors not closing properly will be repaired as identified. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** Maintenance will report to QAPI monthly. Administrator to monitor.	
K 0372 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers			

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	are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure openings through 1 of 2 ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes, and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, the following openings were noted in the ceiling smoke barrier on the first floor: a. the annular space surrounding a one inch in diameter pipe which penetrated the hallway ceiling outside the MDS room was not firestopped. b. a four inch by two inch hole was noted next to the ceiling mounted fan in the Shower Room by	K 0372	**K372** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** All areas identified with holes and not sealed will be sealed with appropriate fire-retardant caulk. Electrical conduits in the ceiling of Mechanical Room will be repaired/replaced. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected by this deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice** does **not recur:** The previous maintenance man did not seek advise on how to repair facility. He was 95% responsible for the citations we have received. We have a new maintenance team who have knowledge of codes and	06/30/2021

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	Room 8. c. the annular space surrounding an electrical conduit which penetrated the ceiling of the Dietary Office in the kitchen was not firestopped. d. foam was used to firestop two holes in the Dietary Office in the kitchen. e. foam was used to firestop the annular space surrounding an electrical conduit in the ceiling above the dishwashing machine in the kitchen. f. a black substance was used to firestop the annular space surrounding three electrical conduits which penetrated the ceiling of the Main Mechanical Room by the main Dining Room. Based on interview at the time of the observations, the Maintenance Director stated fire resistance rating documentation for the foam and the black substance was not available for review and agreed the aforementioned openings in the ceiling smoke barrier were not protected to maintain the fire resistance rating of the ceiling smoke barrier. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		requirements. We now have common sense and knowledge of Life Safety. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** Maintenance will review monthly at QAPI items of repair and method. Administrator will have approved prior to work being done. Maintenance/designated employee will monitor.	
K 0374 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height			

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	are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 1 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, the smoke barrier door set at the top of the ramp in the corridor by Room 6 failed to fully self close when tested to close multiple times. The two doors in the door set each swing in the same direction and was equipped with a door closing coordinator affixed to the top of the door frame near the center of the door frame. The coordinator failed to operate correctly and propped the north door open with a four inch gap in between the meeting edges of the door set. Each door in the door set was held in the fully open position with magnetic holding devices set to release each door to close with fire alarm system activation. Based on interview at the time of the observations, the	K 0374	**K374** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Fire doors at the top of the ramp will be repaired or replaced. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents could be affected by this deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice** does **not recur:** We have a new Maintenance team that is aware of what needs to be done and how to do it. During Fire Drills the doors will be checked for proper closure to prevent the spread in the event of a fire. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance**	06/30/2021

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	Maintenance Director agreed the smoke barrier door set failed to fully self close to restrict the passage of smoke due to the closing coordinator not functioning correctly. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**program will be put in place:** Report to Administrator and QAPI monthly with other door reports. Maintenance responsible Administrator or designee to monitor.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure receptacles in 1 of 19 resident sleeping rooms were properly grounded in accordance with NFPA 70. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition at 406.4 General Installation Requirements states receptacle outlets shall be located in branch circuits in accordance with Part III of Article 210. General installation requirements shall be in accordance with 406.4(A) through (F). (A) Grounding Type. Receptacles installed on 15- and 20-ampere branch circuits shall be of the grounding type. Grounding-type receptacles shall be installed only on circuits of the voltage class and current for which they	K 0511	**K511** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Wall mounted outlet box will be repaired on 6/2/2021 to not have a open ground. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Any resident could be affected by this deficient practice. **What measures will be put into place and what systemic**	06/30/2021

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	are rated, except as provided in Table 210.21(B)(2) and Table 210.21(B)(3). Exception: Nongrounding-type receptacles installed in accordance with 406.4(D). (B) To Be Grounded. Receptacles and cord connectors that have equipment grounding conductor contacts shall have those contacts connected to an equipment grounding conductor. Exception No. 1: Receptacles mounted on portable and vehicle-mounted generators in accordance with 250.34. Exception No. 2: Replacement receptacles as permitted by 406.4(D). (C) Methods of Grounding. The equipment grounding conductor contacts of receptacles and cord connectors shall be grounded by connection to the equipment grounding conductor of the circuit supplying the receptacle or cord connector. The branch-circuit wiring method shall include or provide an equipment grounding conductor to which the equipment grounding conductor contacts of the receptacle or cord connector are connected. Informational Note No. 1: See 250.118 for acceptable grounding means. Informational Note No. 2: For extensions of existing branch circuits, see 250.130. This deficient practice could affect two residents and staff. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, the wall mounted outlet box containing two electrical receptacles near the corridor door in Room 18 was found to have an open ground when tested with an Ideal		**changes will be made to ensure that the deficient practice** does **not recur:** During preventative maintenance rounds all electrical outlets will be inspected by Maintenance. Should there be a deficient outlet, it will be sent to our electrician for repair. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** The preventative maintenance rounds will be reviewed during QAPI by Maintenance. Administrator or designee will monitor weekly.	

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	Industries UL listed circuit tester testing device. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned receptacle location had an open ground when tested with the device. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 electrical wiring in the kitchen dishwashing area was protected. NFPA 70, National Electric Code, 2011 Edition. Article 300.12 Mechanical Continuity - Raceways and Cables states metal raceways shall be continuous between cabinets, boxes, fittings, or other enclosures or outlets. This deficient practice could affect over two staff in the kitchen. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, the metal raceway up against the wall by the kitchen dishwashing machine had a two inch hole in the raceway which exposed the electrical wiring in the raceway. Based on interview at the time of the observations, the Maintenance Director agreed the metal raceway in the kitchen had exposed wiring. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference.			

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	3.1-19(b)			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to provide documentation of a fire drill conducted on the second shift for 2 of 4 quarters. This deficient practice affects all residents, staff, and visitors. Findings include: Based on review of "Fire Drill Report" documentation with the Administrator and the Maintenance Director during record review from 9:10 a.m. to 12:25 p.m. on 05/26/21, documentation of a fire drill conducted on the second shift in the third quarter (July, August, September) 2020 and the fourth quarter (October, November, December) 2020 was not available for review. Based on interview at the time of record review, the Maintenance Director stated the facility operates three shifts per day and conducts fire drills on each shift. The Maintenance Director stated documentation of second shift staff training on fire drill procedures in the third and fourth quarter 2020	K 0712	**K712** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Past fire drills could not be found. Fire drills will be current going forward. They will be made available in the manual. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents can have the potential to be affected by this deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice** does	06/30/2021

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	to serve as a replacement for fire drills conducted during the Covid-19 pandemic was also not available for review. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to document the time of day 1 of 4 third shift fire drills were conducted within the most recent twelve month period. This deficient practice affects all residents, staff, and visitors. Findings include: Based on review of "Fire Drill Report" documentation with the Administrator and the Maintenance Director during record review from 9:10 a.m. to 12:25 p.m. on 05/26/21, documentation for the third shift fire drill conducted on 05/28/20 in the second quarter (April, May, June) 2020 did not include the time of day the fire drill was conducted. The 05/28/20 fire drill documentation stated it was a third shift fire drill. Based on interview at the time of record review, the Maintenance Director stated the facility operates three shifts per day and conducts fire drills on each shift. The Maintenance Director agreed the 05/28/20 third shift fire drill documentation did not include the time of day the fire drill was conducted and stated documentation of staff training on fire drill procedures in the second quarter 2020 to serve as a replacement for fire drills conducted during the Covid-19 pandemic was also not available for review.		**not recur:** Maintenance Supervisor will be responsible for monitoring fire drills on all shifts. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** Maintenance Supervisor will monitor. A report from Maintenance will be given to QAPI monthly for 3 months. Then quarterly thereafter. Maintenance responsible, Maintenance Supervisor will monitor	

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	This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0741 SS=D Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview, the facility failed to ensure smoking materials were	K 0741	**K741**	06/30/2021

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	deposited into ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design in 1 of 2 outdoor areas where smoking was taking place. This deficient practice could affect over two staff and visitors in the vicinity of the outdoor smoking area by the kitchen exit door to the outside of the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, over 10 cigarette butts were deposited into an open top aluminum soda can on a table in the outdoor smoking area by the kitchen exit door. Ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design were not provided at this location. Based on interview at the time of the observations, the Maintenance Director agreed cigarette butts were not deposited into ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design at this outdoor location where smoking was taking place. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** All non-approved ashtrays were removed from the patio. They are replaced with goose neck self -extinguishing models. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents could be affected by this deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice** does **not recur:** New approved smoking receptacles have been provided. They will be replaced as necessary and emptied into a metal container when they are full. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** Activities Director is responsible for use of new ash receptacles. Will notify Administrator or designee when receptacles need replaced. Activities responsible, Administrator or designee to monitor	

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K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure 4 of 4 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	K 0920	**K920** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** All rooms, corridors and offices will have appropriate cords. To allow medical devices to be plugged into a receptacle or on its	06/30/2021

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	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 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 all residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, the following was noted: a. a UL 1363A power strip was mounted on the wall in the corridor by Room 3. A wall mounted electronic read out device was plugged into a wheelchair weigh scale and the power strip in the corridor. b. a television and two cell phone charging cables were plugged into a power strip on the floor one foot from the resident bed nearest the corridor door in Room 3. The UL listing of the power strip was 60601-1. c. a CPAP machine, a television, a cell phone		own hospital grade outlet. The scale will be secured to the wall/and or removed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected by this deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Each room will have outlets and extension cords checked with preventative maintenance rounds. This will be part of the report given to the Maintenance Supervisor/Administrator on a weekly basis. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** Preventative Maintenance Rounds will be reviewed by Maintenance Supervisor. Monthly Maintenance will present a recap of items corrected from maintenance rounds to QAPI	

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	charger and a Pac-Man joystick were plugged into a power strip on the floor one foot from the resident bed in Room 8. The UL listing of the power strip was 60601-1. d. an oxygen concentrator was plugged into a power strip on the floor within three feet of the resident bed in Room 18. The UL listing of the power strip was 60601-1. Based on interview at the time of the observations, the Maintenance Director agreed power strips were being used for PCREE and non-PCREE within the patient care vicinity and as a substitute for fixed wiring. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 7 of 7 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. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, the following was noted:			

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	a. the microwave oven in the second floor conference room was plugged into an extension cord which was plugged into a power strip. b. a refrigerator was plugged into a power strip in the second floor hallway outside the restroom. c. an operating window mounted air conditioner and a fan were plugged into a power strip in the Human Resources Office on the second floor. d. an operating window mounted air conditioner was plugged into an extension cord in the Administrator's Office on the second floor. e. the water softener and the controls for the water heater in the Mechanical Room by the Dining Room were plugged into a power strip. f. the ice machine and a microwave oven were plugged into a power strip in the Nutrition Room in the Dining Room. Based on interview at the time of observation, the Maintenance Director agreed power strips and extension cords were being used as a substitute for fixed wiring in the aforementioned locations. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an			

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	enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 1 of 1 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.3 states storage for nonflammable gases with a total volume equal to or less than greater	K 0923	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** All oxygen cylinders have been secured or returned to the	06/30/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E667	A. BUILDING 01 B. WING	05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNHURST HEALTHCARE	5225 W MORRIS ST INDIANAPOLIS, IN 46241

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	than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1 and 11.3.3.2. NFPA 99, Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect over one staff and visitor in the Soiled Utility Room by the east exit door set in the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:10 p.m. on 05/26/21, one of one 'E' type oxygen cylinders was hanging from a wall mounted rack in the Soiled Utility Room by the east exit door set in the facility and was not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of the observations, the Maintenance Director agreed one of one oxygen cylinders in the Soiled Utility Room was not properly chained or supported in a proper cylinder stand or cart. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		provider. The sign for O2 has been installed. All rooms are being check for the need of 02 signs. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected by this deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice** does **not recur:** When the oxygen provider comes, check to be sure the sign is still there. Monthly get a list of those on oxygen and check to see if signs are in place. DON during rounds will verify all cylinders are secured. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** During morning meeting when new orders are read, DON will make sure new users have signs on their doors. Administrator or Designee will monitor.	