STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING -- B. WING	03/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF TIPTON SKILLED NURSING FACILITY, THE	300 FAIRGROUNDS RD TIPTON, IN 46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/07/23 Facility Number: 000505 Provider Number: 155556 AIM Number: 100266350 At this Emergency Preparedness survey, The Waters of Tipton Skilled Nursing Facility was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 150 and had a census of 98 at the time of this survey. Quality Review completed on 03/14/23	E 0000	March 24, 2023 Brenda Buroker, Director Long term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Survey Event ID: YYZR21 Please accept the following plan of correction as credible evidence of compliance to the deficiencies cited during our recent Annual Life Safety Code Recertification Survey on March 7, 2023 at The Waters of Tipton SNF. Hopefully, you will find that our remedies are both sufficient and thoroughly explained in providing you a clear picture of how we corrected these concerns. With this submission of these remedies, ***we are requesting paper compliance.*** If after reviewing our plan of correction, you have any questions, or require further information, please do not hesitate to contact me at your convenience at 765-675-8791. Respectfully submitted, Paula Juday, HFA, LMSW Administrator The Waters of Tipton	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paula Juday	Administrator	03/24/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/07/2023 Facility Number: 000505 Provider Number: 155556 AIM Number: 100266350 At this Life Safety Code survey, The Waters of Tipton Skilled Nursing Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 150 and had a census of 98 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 03/14/23	K 0000	March 24, 2023 Brenda Buroker, Director Long term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Survey Event ID: YYZR21 Please accept the following plan of correction as credible evidence of compliance to the deficiencies cited during our recent Annual Life Safety Code Recertification Survey on March 7, 2023 at The Waters of Tipton SNF. Hopefully, you will find that our remedies are both sufficient and thoroughly explained in providing you a clear picture of how we corrected these concerns. With this submission of these remedies, ***we are requesting paper compliance.*** If after reviewing our plan of correction, you have any questions, or require further information, please do not hesitate to contact me at your convenience at 765-675-8791. Respectfully submitted, Paula Juday, HFA, LMSW	

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			Administrator The Waters of Tipton	
K 0211 SS=E 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 2 of 2 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects 20 residents. Findings include: Based on an observation during a tour of the facility with the Maintenance Assistant (MA) on 03/07/23 at 3:25 p.m., in the corridor by room 8 and again by room 22, there was a chair and overbed table against the wall protruding into the corridor about two feet. Based on an interview at the time of observations, the MA agreed it was a workspace in the corridor. These findings were reviewed with the Administrator and MA at the exit conference. 3.1-19(b)	K 0211	**DISCLAIMER STATEMENT:** **Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.** **K211** – It is the intent of the facility to ensure corridor means of egresses are continuously maintained free of all obstructions to meet set standards.	03/24/2023

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			1. **CORRECTIVE ACTIONS TAKEN**: a. On 3/8/2023 the Maintenance Supervisor/designee removed the chair and overbed table from the corridor by room 8 and by room 22 to meet set standards. The Administrator verified the work on 3/8/2023. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 3/8/2023 the Maintenance Supervisor/designee inspected all corridor means of egress and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 3/8/2023 the Administrator inserviced the Maintenance Supervisor/designee andon 3/24/23 all other staff on the requirement that the corridor means of egress are to remain free of obstructions to meet set standards. b. Maintenance Supervisor/designee will inspect all corridor means of egress throughout the facility weekly for obstructions as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review	

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			with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3/24/2023.**	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:			

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

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	18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 1 exit doors at the Main entrance was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect 20 residents in the Main entrance area. Findings include: Based on observation with the Maintenance Assistant (MA) on 03/07/23 at 3:10 p.m., the exit door at the Main entrance was marked as a facility exit, was magnetically locked, and could be opened by entering a four-digit code on the access control pad, but the code was not posted at the exit. Based on interview at the time of	K 0222	**K222**– It is the intent of the facility to ensure the means of egress through exit doors at the main entrance is readily accessible for residents without a clinical diagnosis requiring specialized security measures to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 3/8/2023 the Maintenance Supervisor/designee posted information on how to obtain the code at the exit door at the Main Entrance to meet set standards. The Administrator verified the work on 3/8/2023. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 3/8/2023 the Maintenance	03/24/2023

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	observation, the MA agreed the code to open the exit door was not posted by the access control pad and stated there was a concern with a resident leaving the facility. This finding was reviewed with the Adminstrator and MA during the exit conference. 3.1-19(b)		Supervisor/designee inspected all doors to ensure information on how to obtain the codes was present and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 3/8/8023 the Administrator inserviced the Maintenance Supervisor/designee and on 3/24/2023 all other staff on the requirement that information to obtain the codes must be posted at the exit doors to meet set standards. b. Maintenance Supervisor/designee will inspect all means of corridor doors weekly to ensure they have information on how to obtain the codes as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the	

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			Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3/24/2023.**	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on records review and interview, the facility failed to ensure 9 of 9 battery backup emergency lights were tested annually for 90 minutes. 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 in the facility.	K 0291	**K291** – It is the intent of the facility to ensure battery backup emergency lights are tested annually for 90 minutes to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 3/24/2023 the Maintenance Supervisor/designee conducted the annual testing for the battery backup emergency lights that was past due and documented the results on the Battery-Operated Emergency	03/24/2023

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	Findings include: Based on records review with the Maintenance Assistant (MA) on 03/07/23 at 11:55 a.m., annual testing for the battery backup emergency lights was past due. Based on an interview at the time of records review, the MA stated the annual 90 minute testing for the nine battery backup emergency lights has not been conducted in the past 12 months and was past due. 3.1-19(b)		Lights and signs Test Log to meet set standards. The Administrator verified the work on 3/24/2023. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 3/8/2023 the Administrator inserviced the Maintenance Supervisor/designee on the requirement to provide and maintain emergency lighting and conduct the monthly and annual testing and document the results to meet set standards. 2.Maintenance Supervisor/designee will ensure to provide and maintain emergency lighting and conduct the monthly and annual testing as a part of the facility's Preventive Maintenance Program and document those tests on the Battery-Operated Emergency Lights and signs Test Log and will maintain emergency lighting to meet set standards. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance	

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			documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3/24/2023.**	
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			

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	do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 1 storage rooms on the 2nd floor dining area with large amounts of combustible storage and greater than 50 square feet was protected as a hazardous area. This deficient practice could affect 30 residents in the 2nd floor dining area. Findings include: Based on observation during a tour of the facility with Maintenance Assistant on 03/07/23 at 2:50 p.m., the 2nd floor dining area storage room contained over 20 boxes of supplies and was greater than 50 square feet making this a hazardous area. The storage room was not protected as a hazardous area because there was no corridor door. Based on interview at the time of observation, the Maintenance Assistant agreed the storage room contained a large amount of	K 0321	**K321**– It is the intent of the facility to ensure storage rooms on the 2nd floor dining area with large amounts of combustible storage and greater than 50 square feet is protected as a hazardous area to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 3/24/2023 the Maintenance Supervisor/designee removed the boxes of supplies from the 2nd floor dining area storage room to meet set standards. The Administrator verified the work on 3/24/2023. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to	03/24/2023

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	combustible storage, was larger than 50 square feet, and there was no corridor door. The finding was reviewed with the Administrator and the Maintenance Assistant during the exit conference. 3.1-19(b)		be affected but none were. On 3/24/2023 the Maintenance Supervisor/designee inspected all hazardous areas for combustible storage and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 3/8/2023 the Administrator inserviced the Maintenance Supervisor/designee/ and 3/24/2023 all staff on the requirement that all hazardous areas must be protected with a corridor door to meet set standards. b. Maintenance Supervisor/designee will inspect all hazardous areas throughout the facility to ensure there is a corridor door as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance	

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WATERS OF TIPTON SKILLED NURSING FACILITY, THE	300 FAIRGROUNDS RD TIPTON, IN 46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3/24/2023.**	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to			

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	NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure staff had access to the shutoff switch for 1 of 1 electric range in the back Dining room. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect one resident in the back Dining room. Findings include: Based on observation with the Maintenance Assistant (MA) on 03/07/23 at 3:55 p.m., there was an electric range in the back Dining room that was separated from the corridor, but staff did not deactivate the range from power when the kitchen was not under staff supervision. Based on	K 0324	**K324**– It is the intent of the facility to ensure staff has access to the shutoff switch for the electric range in the back Dining Room to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On 3/8/2023 the Administrator/designee inserviced the Activities Department Staff/designee on the requirement to deactivate the power to the electric range in the back Dining Room when the kitchen is not under staff supervision and to ensure the cabinet is locked to meet set standards. The cabinet was locked on 3/8/2023. The Administrator verified the work on 3/8/2023 . **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. **3. MEASURES TO PREVENT REOCCURRENCE**: a. Maintenance Supervisor/Activity Staff/designee will ensure they have access to the shutoff switch for electric ranges as appropriate and ensure it is shut down when not under staff supervision and ensure the cabinet is locked at all times when	03/08/2023

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	interview at the time of observation, the MA was asked if staff were able to deactivate the cooktop and lock the switch. The MA agreed the shut off switch is in a locked cabinet but staff neglected to deactivate the power before they left the area. The finding was reviewed with the Administrator and MA during the exit conference. 3.1-19(b)		not in use. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. b. The Administrator will monitor adherence to the Policies and Procedures regarding the use of the range in the back dining room area. **4. MONITORING CORRECTIVE ACTION**: a. The monitoring results will be presented by the Administrator at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3/8/2023.**	
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.			

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	Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with 19.3.5.3. NFPA 25, 2011 Edition, 14.2.1 states except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Assistant (MA) on 03/07/23 at 1:55 p.m., the internal inspection of piping documentation was not found. Based on interview at the time of record review, the MA agreed there was no documentation of an internal pipe inspection completed in the last 5 years. This finding was reviewed with the Administrator and MA at the exit conference. 3.1-19(b)	K 0353	**K353** – It is the intent of the facility to ensure to maintain the sprinkler system in accordance with 19.3.5.3 to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 3/8/2023 the Maintenance Supervisor/designee received the documentation of their last 5 year internal pipe inspection and documented the results to meet set standards. The Administrator verified the work on 3/8/2023. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 3/8/2023 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that the	03/08/2023

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			sprinkler system must have an internal pipe inspection every 5 years and results documented at the facility to meet set standards. 2.Maintenance Supervisor/designee will ensure the 5 year internal pipe inspection of the sprinkler system is conducted as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure	

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			compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3/8/2023.**	
K 0355 SS=D Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the maintenance shop were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice could affect staff in the maintenance shop. Findings include: Based on observations during a tour of the facility with the Maintenance Assistant on 03/07/23 at 4:15 p.m., a portable fire extinguisher in the maintenance shop was sitting on the floor unsecured. Based on interview at the time of observation, the Maintenance Director agreed the extinguisher was sitting on the floor.	K 0355	**K355**– It is the intent of the facility to ensure portable fire extinguishers are installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 edition to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: a. On 3/8/2023 the facilities Maintenance Supervisor/designee secured the portable fire extinguisher in the maintenance shop to meet set standards. The Administrator verified the work on 3/8/2023. **1.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **2.MEASURES TO PREVENT REOCCURRENCE**: 1.On 3/8/2023 the	03/08/2023

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	Thid finding was reviewed with the Administrator and Maintenace Assistant at the exit conference. 3.1-19(b)		Administrator inserviced the Maintenance Supervisor/designee that portable fire extinguishers must be installed in accordance with NFPA 10 to meet set standards. 2.Maintenance Supervisor/designee will ensure portable fire extinguishers are readily accessible and installed in accordance with NFPA 10 as a part of the facility's Monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **3.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with	

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			subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3/8/2023.**	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 1. Based on observation and interview, the facility failed to ensure 1 of 1 rooms with a large quantity of combustible storage open to the corridor was not used as hazardous storage. LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect 15 residents in the Activity office area. Findings include:	K 0361	**K361** – It is the intent of the facility to ensure rooms with a large quantity of combustible storage open to the corridor is not used as hazardous storage and to ensure nursing station with a pass-through window greater than 20 square inches meet the requirements of spaces open to the corridor to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 3/24/2023 the Maintenance Supervisor/designee removed the combustible materials from the Activity office area including the boxes of supplies, plastic containers and	03/24/2023

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	Based on observation with the Maintenance Assistant (MA) on 03/07/23 at 4:00 p.m., the Activity office area was open to the corridor and was being used to store combustible material such as boxes of supplies, plastic containers, and activity items. This condition does not protect the corridor from a hazardous storage area. Based on interview at the time of observation, MA agreed the Activity office was open to the corridor and it was being used to store Activity supplies. 2. Based on observation and interview, the facility failed to ensure 1 of 1 nursing station with a pass-through window greater than 20 square inches met the requirements of spaces open to the corridor. LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. LCS 19.3.6.5.1 states miscellaneous openings, such as mail slots, pharmacy pass-through windows, laboratory pass-through windows, and cashier pass-through windows, shall be permitted to be installed in vision panels or doors without special protection, provided that both of the following criteria are met: (1) The aggregate area of openings per room does not exceed 20 inches squared (0.015 m2). (2) The openings are installed at or below half the distance from the floor to the room ceiling. This deficient practice could affect staff and up to 20 residents in one smoke compartments. Based on observation with the Maintenance		activity items to meet set standards. b. On 3/8/2023 the Maintenance Supervisor/designee installed plexiglass to the 2nd floor nursing station window, that is no longer used as a nurse's station that had an opening at the ceiling to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. The administrator inserviced the maintenance supervisor on 3/8/2023 and all staff on 3/24/2023 to ensure rooms without a locking door are not used for storing combustible materials and ensure nursing station with a pass-through window greater than 20 sq. inches meet the requirements of spaces open to the corridor to meet set standards. b. Maintenance Supervisor/designee will inspect all corridors throughout the facility weekly to ensure there are no rooms without a locking door used for storing combustibles and ensure nursing stations with a pass-through window greater than 2- sq inches meet the requirements of spaces open to the corridor as appropriate. If any issues are discovered, they will be addressed and resolved	

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	Director on 03/7/23 at 3:00 p.m., the 2nd floor nursing station, that was no longer used as a nurses station, had an opening at the ceiling exceeding 20 square inches and was not protected by an electrically supervised automatic smoke detection. Based on interview at the time of observation, the Maintenance Director agreed the window was greater than 20 square inches and the 2nd floor former nursing station was not provided with an electrically supervised automatic smoke detection device. These findings were reviewed with the Administrator and MA during the exit conference. 3.1-19(b)		immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3/24/2023.**	
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			

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	of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 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 2 of 2 corridor doors were provided with a means suitable for keeping the	K 0363	**K363** – It is the intent of the facility to ensure corridor doors are provided with a means suitable for	03/24/2023

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	door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 6 residents. Findings include: 1. Based on observation with the Maintenance Assistant (MA) on 03/07/23 at 3:25 p.m., the corridor closet door by room 8 would not latch into the frame when tested. Based on interview at the time of observation, the MA agreed the corridor door would not close into the door frame. 2. Based on observation with the MA on 03/07/23 at 3:45 pm, the double doors from the corridor to the Therapy Gym did not have positive latching hardware. These findings were reviewed with the Administrator and MA during the exit conference. 3.1-19(b)		keeping the door closed, has no impediment to closing, latching and will resist the passage of smoke to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On 3/8/2023 the Maintenance Supervisor/designee repaired the latching mechanism in the corridor closet door by room 8 so it would latch fully into the frame to meet set standards. The Administrator verified the repairs on 3/8/2023. b. On 3/24/2023 the Maintenance Supervisor/designee installed positive latching hardware to the double doors from the corridor to the Therapy Gym to meet set standards. The Administrator verified the repairs on 3/24/2023 . **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee inspected all corridor doors to ensure they latch fully into the frame and for positive latching hardware and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 3/8/2023 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that corridor doors latch fully into the frame and	

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			have positive latching hardware to meet set standards. b. Maintenance Supervisor/designee will inspect all corridor doors throughout the facility monthly to ensure they latch fully into the frame and have positive latching hardware as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	

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	155556	A. BUILDING 01 B. WING	03/07/2023

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			This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3/24/2023	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills on each shift for 2 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on records review with the Maintenance Assistant and the Administrator on 03/07/23 at 10:30 a.m., the following shifts were missing documentation of a completed fire drill: a) A second shift fire drill in the third quarter of 2023.	K 0712	**K712** – It is the intent of the facility to ensure to conduct fire drills on each shift for all four quarters to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 3/8/2023 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that fire drills must be conducted at unexpected times under varying conditions at least quarterly on each shift and documented to meet set standards. b. On 3/24/2023 the Maintenance Supervisor/designee conducted a fire drill/training for	03/24/2023

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	b) A first shift fire drill in the fourth quarter of 2023. Based on interview at the time of record review, the Maintenance Assistant stated the drills were completed but could not find the documentation to show the aforementioned drills were conducted. This finding was reviewed with the Administrator and Maintenance Assistant at the exit conference. 3.1-19(b)		each of the three shifts and documented the results in the facilities Life Safety Binder to meet set standards. The Administrator verified the drills on 3/24/2023. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. Maintenance Supervisor/designee will ensure fire drills are conducted at unexpected times under varying conditions at least quarterly on each shift and documented on the Fire Drill Report and that documentation be retained in the facility's Life Safety Binder as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. b. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will	

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			be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3/24/2023.**	
K 0753 SS=D Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present.			

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	19.7.5.6 Based on observation and interview, the facility failed to ensure 1 of 1 corridor doors was covered with decorations that did not exceed 30 percent of the door. LSC 19.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 18.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient	K 0753	**K753** – It is the intent of the facility to ensure corridor doors are not covered with decorations that exceed 30 percent of the door to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 3/8/2023 the Maintenance Supervisor/designee removed the quilt decoration that covered at least 40% of resident room 11's door to meet set standards. The Administrator verified the removal on 3/8/2023. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 3/8/2023 the Maintenance Supervisor/designee inspected all rooms throughout the facility for decorations and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 3/8/2023 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that corridor doors cannot be covered with decorations that exceed over 30 percent of the door to meet set standards. b. Maintenance Supervisor/designee will inspect all rooms throughout the facility weekly for decorations on the	03/08/2023

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	sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. This deficient practice could affect 2 residents in resident room 11. Findings include: Based on an observation during a tour of the facility with the Maintenance Director on 03/07/23 at 03:20 p.m., resident room 11 door was covered by a quilt decoration that covered at least 40% of the door. Based on interview at the time of the observation, the Maintenance Assistant agreed the corridor door was partially covered with a combustible decoration. This finding was reviewed with the Administrator and Maintenance Assistant at the exit conference. 3.1-19(b)		corridor doors as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3/8/2023**	

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K 0761 SS=F Bldg. 01	Based on records review and interview, the facility failed to ensure annual inspection and testing of fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.	K 0761	**K761** – It is the intent of the facility to ensure annual inspection and testing of all fire door assemblies are completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 3/8/2023 the Maintenance Supervisor/designee conducted the annual inspection for the fire door assemblies and documented those inspection results on the Annual Door Inspections log to meet set standards. The Administrator verified the inspections and documentation on 3/8/2023 . 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 3/8/2023 the Administrator/corporate Property Manager inserviced the Maintenance Supervisor/designee on the requirement that annual testing & inspections of fire door	03/08/2023

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	(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include: Based on record review with the Maintenance Assistant (MA) on 03/07/23, no current documentation of an annual inspection for the fire door assemblies was available for review. The last record of fire door inspection was completed in 02/18/22. Based on interview at the time of records review and observation, the MA stated the annual fire door inspection was not completed within the last year. This finding was reviewed with the Administrator and MA at the exit conference. 3.1-19(b)		assemblies must be conducted to ensure proper operation and documented on the Annual Door Inspections log to meet set standards. b. Maintenance Supervisor/designee will conduct the annual inspection of fire door assemblies to ensure proper operation and document the inspection results on the Annual Door Inspection log as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with	

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			subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3/8/2023.**	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review and interview, the facility	K 0914	**K914**– It is the intent of the facility	03/08/2023

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	failed to ensure non-hospital grade electrical receptacles in resident sleeping rooms were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on records review with the Maintenance Assistant (MA) on 3/7/23 at 11:30 a.m., no documentation was available to show that testing of the electrical receptacles in resident sleeping rooms was completed during the last 12 months. Based on interview at the time of the record review, the Maintenance Assistant confirmed all the electrical receptacles in the resident sleeping rooms were not hospital-grade and stated it is unknown the last time the annual testing was completed. This finding was reviewed with the Administrator and MA during the exit conference. 3.1-19(b)		to ensure nonhospital grade electrical receptacles in resident sleeping rooms are tested at least annually to meet set standards. **1) CORRECTIVE ACTIONS TAKEN**: a) On 3/8/2023 The Administrator inserviced the Maintenance Supervisor on the requirement to test non-hospital grade electrical receptacles installed in resident sleeping rooms throughout the building annually to meet set standards. b) On 3/8/2023 the Maintenance Supervisor/designee conducted the annual inspection of the non-hospital grade electrical receptacles installed in resident sleeping rooms throughout the building and documented the results on the Annual Receptacle Testing Log to meet set standards. The Administrator verified the inspections and documentation on 3/8/2023 . **2) ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a) All residents and all staff and visitors have the potential to be affected but none were. **3) MEASURES TO PREVENT REOCCURRENCE**: a) On 3/8/2023 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that non-hospital grade electrical receptacles in resident sleeping rooms must be tested annually	

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			and documented on the Annual Receptacle Testing Log to meet set standards. b) Maintenance Supervisor/designee will ensure to properly test non-hospital grade electrical receptacles installed in resident sleeping rooms throughout the building annually as part of the facility's Preventive Maintenance Program and document those inspection results on the Annual Receptacle Testing Log as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c) The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4) MONITORING CORRECTIVE ACTION**: a) The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator annually and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction	

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			developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3/8/2023.**	
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 Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used	K 0920	**K920** – It is the intent of the facility to ensure power strips are	03/24/2023

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WATERS OF TIPTON SKILLED NURSING FACILITY, THE	300 FAIRGROUNDS RD TIPTON, IN 46072

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	as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 5 residents in the Activity office area. Findings include: Based on observations during a tour of the facility with the Maintenance Assistant (MA) on 03/07/23 at 4:00 p.m. a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in the Activity office. Based on interview at the time of observation, the Maintenance Assistant acknowledged a power strip was supplying power to high power draw equipment. This finding was reviewed with the Administrator and MA at the exit conference. 3.1-19(b)		not used as a substitute for fixed wiring to provide power equipment with a high current draw to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 3/8/2023 the Maintenance Supervisor/designee removed the power strip from the Activity office that was being used to power a refrigerator to meet set standards. The Administrator verified the removal on 3/8/2023 . **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. On 3/8/2023 the Maintenance Supervisor/designee inspected all rooms throughout the facility for power strips and found no other negative findings. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 3/8/2023 the Administrator inserviced the Maintenance Supervisor/designee/ and on 3/24/2023 all other staff that power strips are not to be used as a substitute for fixed wiring to meet set standards. 2.Maintenance Supervisor/designee will inspect all rooms throughout the facility monthly to ensure they do not have power strips in use as a part of the facility's Preventive Maintenance Program and	

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	155556	A. BUILDING 01 B. WING	03/07/2023

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			document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3/24/2023.**	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag			

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	155556	A. BUILDING 01 B. WING	03/07/2023

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	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 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			

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	99) Based on observation and interview, the facility failed to ensure empty oxygen cylinders are segregated from full cylinders and are marked to avoid confusion. This deficient practice could affect up to 15 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Assistant (MA) on 03/07/23 at 3:50 p.m. in the oxygen storage room there was no means to separate full cylinders from empty cylinders. Based on interview at the time of observation, the MA stated that there was no empty cylinder section designated in the oxygen storage room. The finding was reviewed with the Administrator and MA during the exit conference. 3.1-19(b)	K 0923	**K923** – It is the intent of the facility to ensure empty oxygen cylinders are segregated from full cylinders and are marked to avoid confusion to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 3/23/2023 the Director of Nursing/designee installed signage in the Oxygen Storage Room to separate full cylinders from empty cylinders to meet set standards. The Administrator verified the work on 3/23/2023. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 3/23/2023 DON/designee checked all areas of the facility for improperly stored oxygen cylinders and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 3/8/2023 the Administrator inserviced the DON/designee and on 3/24/2023 all other nursing staff on the requirement that empty oxygen cylinders must be segregated from full cylinders and marked to avoid confusion to meet set standards. b. The Director of Nursing/designee will inspect all oxygen cylinders weekly to ensure the empty cylinders are segregated from the full cylinders	03/24/2023

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			as a part of the facility's Oxygen Policy and Procedures Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Oxygen Policy & Procedures schedule and validate the Oxygen Policy & Procedures are in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3/24/2023.**	