STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155086	A. BUILDING -- B. WING	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLAND MANOR	343 S NAPPANEE ST ELKHART, IN 46514

(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: 04/05/23 Facility Number: 000034 Provider Number: 155086 AIM Number: 100274880 At this Emergency Preparedness survey, Woodland Manor was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 80 certified beds. At the time of the survey, the census was 69. Quality Review completed on 04/11/23	E 0000		
E 0041 SS=C Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power			

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

Linda Lewis | Administrator | 05/08/2023

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	systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain			

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	the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013.			

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	(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 04/05/23 at 9:50 a.m., the following required testing documentation was not available for review: a.) Generator exercised under load monthly for a minimum of 30 minutes b.) Generator inspected weekly. c.) Generator exercised under load for four (4) continuous hours once every three years. Based on an interview at the time of record review and observation, the Maintenance Director stated the generator runs weekly but no information was recorded within the last 12 months and the generator was not exercised under load for four (4) continuous hours within the last three years. The findings were reviewed with the Administrator and Maintenance Director at the exit conference.	E 0041	E0041 It is the intent of the facility to maintain testing of generator. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; System for monthly and weekly testing of the generator has been established. The 4-hour load test has been set for May 8th, 2023 with Safe Care. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents had a potential to be affected by the deficit practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A quality assurance tool has been developed for weekly and monthly inspection of generator. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Quality Assurance Audit Tool will be completed by the Administrator/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	06/01/2023

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K 0000 Bldg. 01	A Life Safety Code (LSC) Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/05/23 Facility Number: 000034 Provider Number: 155086 AIM Number: 100274880 At this LSC survey visit, Woodland Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and areas open to the corridor and battery operated smoke detectors in the resident rooms. The building is partially protected by a Type II EES 36 kW diesel-powered emergency generator. The facility has a capacity of 80 and had a census of 69 at the time of this survey Quality Review completed on 04/11/23	K 0000		
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit			

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	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 #1.) Based on observation and interview, the facility failed to ensure 1 of 1 cooler doors in the kitchen were able to open from the inside if locked. LSC 19.2.2.1 states doors complying with 7.2.1 shall be permitted. 7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied. This deficient practice could staff in the kitchen. Findings include: Based on observation with the Maintenance Director and the Administrator on 04/05/23 at 11:31 a.m., the kitchen walk-in cooler door could be locked with a padlock from the outside, but there was no release mechanism on the inside of door. This condition could trap a person inside the cooler if locked with a padlock from the outside. Based on interview at the time of observation, the Maintenance Director and the Administrator stated the cooler is locked at night with a padlock and there was not a release mechanism from the inside. #2.) Based on observation and interview, the facility failed to ensure 1 of 7 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects staff in the service hall. Findings include:	K 0211	K211 It is the intent of the facility to provide means of egress of aisles, passageways, corridors and exit discharges. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Cooler door lock has been removed. The new lock with release from the inside has been received and scheduled to install 5.8.2023. The Service Hall cleared of nonmobile items and Soda Vending machine removed from corridor. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents had potential to be affected, cooler located in employee only areas. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Lock which opens from the inside is in place on the walk in cooler. Vending machine removed from service hall. How the corrective action(s) will be	06/01/2023

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	Based on observation with the Maintenance Director 04/05/23 at 11:08 a.m., the service hall exit corridor contained storge taking up over two feet of corridor width. Items included furniture, boxes, and carts. Also, there was a soda machine in the corridor taking up over three and a half feet of the corridor width. Based on an interview at the time of observations, the Maintenance Director agreed there was items stored in the service hall exit corridor and stated the items need to be removed. The findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; A quality assurance tool has been developed to monitor environmental areas as identified during the survey that areas are in good repair. The Quality Assurance Audit Tool will be completed by the Maintenance Director/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6			

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	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. 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			

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	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 7 exit doors by room 300 were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect 20 residents on the 300-hall. Findings include: Based on observation with the Maintenance Director and Administrator on 04/05/23 at 10:30 a.m., the exit door by room 300 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. Also, it took over 10 minutes to open the door because the correct code was unknown. Based on interview at the time of observation, the Maintenance Director agreed the code to open the exit door was not posted by the access control pad. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0222	K222 It is the intent of the facility to provide means of egress doors not equipped with latch or a lock that requires a tool. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Code to exit posted at the exit door by room 300. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The 20 residents residing on Unit 300 had a potential to be affected by the deficit practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A quality assurance tool has been developed to monitor egress door for posting of codes as identified during the survey. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Quality Assurance Audit Tool will be completed by the Maintenance Director/ Designee weekly for three weeks; then monthly for	06/01/2023

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			three months, then quarterly x three. Findings will be reported in QAPI quarterly.	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation and interview, the facility failed to meet the clear width requirement for 1 of 7 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised	K 0232	K232 It is the intent of the facility to provide aisle and corridors serving as an exit shall be at least 4 feet. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Chair removed from the corridor How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents had a potential to be affected by the deficit practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A quality assurance tool has been developed to monitor for unaffixed furniture in the corridor as identified during the survey. Education provided to staff	06/01/2023

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	automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect 20 residents in the 400-hall. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 04/05/23 at 10:46 a.m., two chairs in the corridor by the nurse's station extended about two feet into the corridor and were not affixed to the floor or to the wall when tested. Based on interview at the time of the observations, the Administrator agreed the chairs were not securely attached to the floor or to the wall when tested. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		by Administrator/Designee. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Quality Assurance Audit Tool will be completed by the Maintenance Director/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	
K 0251 SS=E Bldg. 01	NFPA 101 Dead-End Corridors and Common Path of Travel Dead-End Corridors and Common Path of Travel 2012 EXISTING Dead-end corridors shall not exceed 30 feet. Existing dead-end corridors greater than 30 feet shall be permitted to be continued to be used if it is impractical and unfeasible to alter them.			

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	19.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 dead-end corridors did not exceed 30 feet. This deficient practice could 20 residents on the 300-hall. Findings include: Based on observation with the Maintenance Director and Administrator on 04/05/23 at 10:43 a.m., the 300-hall corridor led to a set of closed and locked cross corridor doors leading into memory care without a posted exit sign or posted code to unlock the doors making the hall a dead-end corridor. The corridor measured 100 feet in length exceeding the 30 feet max for a dead-end corridor. Based on interview at the time of observation, the Maintenance Director agreed the hall came to a dead end and stated the doors need an exit sign installed and the code posted in order to reach the next facility exit. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0251	K251 It is the intent of the facility to provide directions related to dead end corridors. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Exit sign placed How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents had a potential to be affected by the deficit practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A quality assurance tool has been developed to monitor for exit signage in the corridor as identified during the survey. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Quality Assurance Audit Tool will be completed by the Maintenance Director/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	06/01/2023
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of 7 exit discharge were provided with an unobstructed level walking surface in accordance with NFPA 101 (2012 edition) section 7.7. This deficient practice could affect staff using the service hall exit. Findings include: Based on observation with the Maintenance Director on 04/05/23 at 12:50 p.m., from the employee exit discharge door the last half of the path of egress to the common way went through the employee parking lot. The entire parking lot was uneven, had loose gravel, had 20 plus large and deep potholes. Due to the parking lot poor shape, there was not a safe unobstructed level walking surface to the common way. Based on interview at the time of observation, the Maintenance Director agreed the path of egress went through the parking lot, was in poor condition, and did not provide an unobstructed level walking surface. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0271	K271 It is the intent of the facility to maintain egress were provided with an unobstructed level walking surface. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Quotes have been obtained and submitted for approval. Temporary solution in place with the area immediately leading into parking lot with no hole and hard level surface taped off with caution tape for no parking until repairs to parking lot can be completed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All resident have potential to be affected by the deficit practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Quality Assurance audit tool developed for inspection of means of egress for unobstructed level walking surface. How the corrective action(s) will be	06/01/2023

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	155086	A. BUILDING 01 B. WING	04/05/2023

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			monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Quality Assurance Audit Tool will be completed by the Administrator/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	
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, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of 47 of 47 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. 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.	K 0300	K300 It is the intent of the facility to provide testing and maintenance of smoke detectors per manufacture recommendations. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All smoke detectors were inspected and tested by Safe Care 4.25.2023. Weekly checks will be maintained by our Maintenance Director/Designee How other residents having the potential to be affected by the same deficient practice will be	06/01/2023

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	Findings include: Based on records review with the Maintenance Director and Administrator on 04/05/23 at 9:41 a.m., a completed itemized list for preventative maintenance of resident room battery operated smoke alarms were not available for review. Furthermore, the manufacture's documentation requires weekly testing and monthly cleaning. Based on interview at the time of review, the Maintenance Director stated the alarms are tested monthly, but the tests are not recorded. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		identified and what corrective action(s) will be taken; All residents had a potential to be affected by the deficit practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A quality assurance tool has been developed to monitor for completion of the weekly inspection and testing of smoke detector. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Quality Assurance Audit Tool will be completed by the Administrator/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	
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 laundry rooms that contained fuel fired equipment were separated from other spaces by smoke resistant partitions. This deficient practice could affect staff in the service hall. Findings include: Based on observation with the Maintenance Director and Administrator on 04/05/23 at 11:11 a.m., in the ceiling of the laundry room containing fuel fired equipment had three unsealed gaps around pipes and there was a 16-inch by 10-inch hole covered with a piece of flimsy plastic that was not smoke tight. Based on interview at the time of the observation, the Maintenance Director agreed there were unsealed penetrations in the ceiling of the laundry room which contained fuel fired equipment.	K 0321	K321 It is the intent of the facility to provide smoke resistant partitions in areas that contain fuel fired equipment. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The ceiling in laundry room has been repaired with drywall on 4.6.2023. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents had a potential to be affected by the deficit practice. What measures will be put into place and what systemic changes will be made to ensure that the	06/01/2023

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	This finding was reviewed with the Maintenance Director and Administrator at the exit conference. 3.1-19(b)		deficient practice does not recur; A quality assurance tool has been developed to monitor ceiling repair. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Quality Assurance Audit Tool will be completed by the Administrator/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1			

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	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 2 of 2 cook tops in the therapy gym and activities 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 10 residents in the therapy gym and activities room. Findings include: Based on observation with the Maintenance Director and adminstrator on 04/05/23 at 10:25 a.m. and 11:10 a.m., there was a cooktop in the therapy gym and in the activities room that were separated from the corridor, but staff were unable to deactivate the cooktops from power. Based on interview at the time of observation, the Maintenance Director was asked if staff were able to deactivate the cooktops and lock the switches. The Maintenance Director stated the shut off	K 0324	K324 It is the intent of the facility to shut off access for staff to kitchen equipment. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Shut off to be installed 5.5.2023 by electrician for stove in activity room and therapy gym. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents had a potential to be affected by the deficit practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A quality assurance tool has been developed to monitor compliance with use of shut off to kitchen equipment in activity room and therapy room. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Quality Assurance Audit Tool will be completed by the Maintenance/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	06/01/2023

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	switches are in two breaker boxes, but staff does not have access to the breaker boxes. This finding was reviewed with the Maintenance Director and Administrator at the exit conference. 3.1-19(b)			
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 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 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, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, Section 14.4.5.3.1 states smoke detector sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states smoke detector sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with Section 14.4.5.3.3. This deficient practice could affect all occupants.	K 0345	K345 It is the intent of the facility to conduct smoke detector sensitivity per guidance. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Sensitivity has been conducted by Safe Care 4.21.2023 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents had a potential to be affected by the deficit practice. What measures will be put into place and what systemic changes will be made to ensure that the	06/01/2023

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	Findings include: Based on record review with the Maintenance Director and Administrator on 04/05/23 at 9:40 a.m., no documentation for a smoke detector sensitivity test was available for review. Based on interview at the time of record review, the Maintenance Director stated the sensitivity test documentation was missing and did not know the last time the sensitivity test was conducted. This finding was reviewed with the Maintenance Director and Administrator at the exit conference. 3.1-19(b)		deficient practice does not recur; A quality assurance tool has been developed to monitor for completion of the monthly for sensitivity testing of smoke detectors. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Quality Assurance Audit Tool will be completed by the Administrator/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 #1.) Based on observation and interview, the	K 0353	K353 It is the intent of the facility	06/01/2023

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	facility failed to ensure 1 of 1 automatic sprinkler system riser was easily accessible and properly protected. NFPA 13, 2010 Edition, 9.3.4.1, Clearance shall be provided around all piping extending through walls, floors, platforms and foundations, including drains, fire department connections and other auxiliary piping. This deficient practice could affect all occupants. Findings include: Based on observation on with the Maintenance Director and Administrator on 04/05/23 at 11:55 a.m. the sprinkler riser was not accessible due to boxes and cleaning items were stored directly in front of and leaning against the sprinkler system riser in the main mechanical room. Based on interview at the time of observation, the Maintenance Director agreed items were stored in front of the sprinkler riser. #2.) Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly, or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This		to maintain ease of accessible access to the automatic sprinkler riser. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The area in front of the riser has been cleared and tape applied to floor to alert no to store item. Monthly inspection of wet fire protection system initiated. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents had a potential to be affected by the deficit practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A quality assurance tool has been developed to monitor compliance with ease of access to the automatic sprinkler riser. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Quality Assurance Audit Tool will be completed by the Maintenance/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	

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	deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and Administrator on 04/05/23 at 09:30 a.m., documentation of monthly inspections for the wet sprinkler system's gauges and the sprinkler system's valves for the past 12 months was not availabel for review. During an interview at the time of record review, the Maintenance Director stated the sprinkler system checks were not conducted within the last year. The findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 4 of 6 portable fire extinguishers in the maintenance shop and main mechanical room 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	K 0355	K355 It is the intent of the facility to securely store fire extinguishers. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Fire extinguishers has been secured. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	06/01/2023

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	recess. This deficient practice could affect staff in the service hall. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Administrator on 04/05/23 at 11:00 a.m., there were three portable fire extinguishers in the maintenance shop and one fire extinguisher in the main mechanical room that were sitting on the floor unsecured. Based on interview at the time of observation, the Maintenance Director agreed extinguishers were sitting on the floor and stated the extinguishers are for training and will be moved out of the building. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		action(s) will be taken; No residents had a potential to be affected by the deficit practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A quality assurance tool has been developed to monitor compliance with storage of fire extinguishers. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Quality Assurance Audit Tool will be completed by the Maintenance/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	
K 0500 SS=F Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation, records review and interview, the facility failed to ensure 2 of 2 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to	K 0500	K500 It is the intent of the facility to ensure water heaters are in safe operating order. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Inspection	06/01/2023

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	minimize the possibility of a fire emergency requiring the evacuation of occupants. The State requires hot water heaters to be inspected once every two years. This deficient practice could affect staff in the service hall. Findings include: Based on observation with the Maintenance Director on 04/05/23 at 11:20 a.m., the two hot water heaters in the main mechanical room had an inspection certificate with an expiration date of December of 2021. Based on records review at 2:00 p.m., no documentation was available for review to show the two water heaters have been inspected since December of 2021. Based on interview at the time of the observation and records review, the Maintenance Director stated an inspection was completed but did not have documentation to show when the inspection took place. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		requested to be completed by licensed vendor 5.8.2023. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents had a potential to be affected by the deficit practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Inspection entered into TELS to alert the up coming need. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Quality Assurance Audit Tool will be completed by the Maintenance/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation, the facility failed to ensure 1 of 1 electrical junction in the records storage	K 0511	K511 It is the intent of the facility to provide proper electrical	06/01/2023

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	room were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director and Administrator on 04/05/23 at 12:10 p.m., an electrical junction connecting a florescent light was not covered and had exposed electrical wiring. Based on interview at the time of the observations, the Maintenance Director agreed the electrical junction was not covered and had exposed wires. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		installation. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Light fixture was repaired 4.15.2023 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 20 residents in one smoke compartment had a potential to be affected by the deficit practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A quality assurance tool has been developed for visual audits conducted for proper electrical installation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Quality Assurance Audit Tool will be completed by the Administrator/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	
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			

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	and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills on each shift for 3 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 Director and the Administrator on 04/05/23 at 08:55 a.m., no fire drills were conducted on all shifts for the second, third, and fourth quarters of 2022. Based on interview at the time of record review, the Maintenance Director stated no fire drills were conducted in 2022 due to lack of training. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	K712 It is the intent of the facility to conduct Fire Drills to include transmission of a fire alarm signal and simulation of emergency fire conditions. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; System established to conduct Fire drills monthly with rotating shifts by maintenance Director/Designee. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents had a potential to be affected by the deficit practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A quality assurance tool has been developed to monitor for completion of the monthly Fire drills. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be	06/01/2023

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			put into place; The Quality Assurance Audit Tool will be completed by the Administrator/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	
K 0741 SS=E 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.			

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	18.7.4, 19.7.4 Based on observation and interview; the facility failed to ensure 3 of 3 smoking areas were maintained by disposing cigarette butts in the provided metal or noncombustible containers with self-closing cover devices. This deficient practice could affect 10 residents in the resident smoking area. Findings include: Based on observation Maintenance Director and Administrator on 04/05/23 between 8:30 a.m. 12:30 p.m., the following smoking areas were not properly maintained: a.) In the front resident smoking area, there were over 10 cigarette butts on the ground. b.) Around the front entrance there were over 100 cigarette butts on the ground and in the planters. c.) In the staff smoking area, there were over 20 cigarette butts on the ground. Based on interview at the time of observations, the Maintenance Director agree cigarette butts were on the ground. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0741	K741 It is the intent of the facility to safe smoking areas outside of the building. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Additional noncombustible ashtrays placed in all smoking areas. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents had a potential to be affected by the deficit practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A quality assurance tool has been developed to monitor smoking areas for cigarette butts. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Quality Assurance Audit Tool will be completed by the Administrator/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	06/01/2023
K 0761 SS=F Bldg. 01				

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	#1.) Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 4 of 4 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. (6) The self-closing device is operational; that is, the active door completely closes when operated	K 0761	K761 It is the intent of the facility to provide testing of fire doors. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Roll door as identified during survey was Inspected on 4.21.2023 and added to Tels Maintenance tracking system. Annual Fire Door Inspection completed and added to Tels system. Paint has been removed from the fire rating symbol. Fire door by room 123 hole has been sealed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents had a potential to be affected by the deficit practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A quality assurance tool has been developed for inspection of the fire doors integrity and that labeling seal is visible. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Quality Assurance Audit Tool will be completed by the Administrator/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. Findings	06/01/2023

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	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 Administrator and Maintenance Director on 04/05/23 at 10:48 a.m., documentation of an annual inspection for the four (4) fire door assemblies were not available for review. Based on observation during the tour between 10:00 a.m. and 1:00 p.m., there are three (3) one-and-a-half-hour cross corridor fire door assemblies and one fire door to the oxygen transfilling room. Based on interview at the time of records review and observation, the Maintenance Director stated the annual fire door inspections were not completed within the last year. #2.) Based on observation and interview, the facility failed to maintain annual testing of 1 of 1 rolling fire door in accordance with NFPA 80. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80 5.2.1 requires fire door		will be reported in QAPI quarterly.	

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	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. This deficient practice could affect 25 residents in the main dining room. Findings include: Based on observation with the Maintenance Director and Administrator on 04/05/23 at 11:30 a.m., there was a rolling fire door/window between the kitchen and dining room. The tag on the rolling fire door indicated the last annual test was performed in 2018. Based on interview at the time of observation, the Maintenance Director stated the fire door/window has not been inspected since 2018. #3.) Based on observation and interview, the facility failed to ensure 3 of 4 fire door assemblies had no field modifications to the door assembly have been performed that void the label in accordance with NFPA 80, section 5.2.4.2 (10). This deficient practice could affect all residents. Findings include: Based on observation with the Maintenance Director on 04/05/23 between 10:55 a.m. and 12:00 p.m., there were three cross corridor fire door assemblies that had the fire rating label covered with paint and the door rating could not be determined. Based on interview at the time of observation, the Maintenance Director agreed the 3 fire door assemblies had paint on the fire rating label. #4.) Based on observation and interview, the facility failed to ensure 1 of 3 smoke barrier doors are routinely inspected and repaired as part of the			

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	facility maintenance program. This deficient practice could affect 20 residents in one smoke compartments. Findings include: Based on observation with the Administrator and Maintenance Director on 04/05/23 at 12:20 p.m., the smoke door assembly by room 123 was damaged due to two (2) ½ inch holes through the smoke doors. Based on interview at the time of observation, the Maintenance Director agreed there was holes in the smoke doors. The findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and			

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	automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on observation, records review, and interview the facility failed to maintain 1 of 1 diesel power generators in accordance with NFPA 99 2012 Chapter 6 which requires monthly and weekly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 04/05/23 at 9:50 a.m., the following required testing documentation was not available for review: a.) Generator exercised under load monthly for a minimum of 30 minutes b.) Generator inspected weekly. c.) Generator exercised under load for four (4) continuous hours once every three years. Based on an interview at the time of record review	K 0918	K918 It is the intent of the facility to maintain testing of generator. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; System for monthly and weekly testing of the generator has been established. The 4-hour load test has been set for May 8th, 2023 with Safe Care. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents had a potential to be affected by the deficit practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	06/01/2023

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	and observation, the Maintenance Director stated the generator runs weekly but no information was recorded within the last 12 months and the generator was not exercised under load for four (4) continuous hours within the last three years. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		A quality assurance tool has been developed for weekly and monthly inspection of generator. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Quality Assurance Audit Tool will be completed by the Administrator/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	
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 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			

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	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)			
	#1) Based on observation and interview, the facility failed to ensure 1 of 2 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. 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 2 residents in room 113. Findings include: Based on observations with the Maintenance Director and Administrator on 04/05/23 at 12:24 p.m., an 'E' type oxygen cylinder was standing	K 0923	K923 It is the intent of the facility to maintain safe storage Oxygen. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Extra Oxygen cylinders were returned to the vendor. Signage for Full or Empty cylinders posted. Oxygen cylinder was removed from room 113 and taken by O2 caddie to O2 room. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 30 residents within the smoke compartment had a potential to be affected by the deficit practice. What measures will be put into place and what systemic changes	06/01/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	upright on the floor in resident room 113 and was not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of observation, the Administrator agreed an 'E' type oxygen cylinder in room 113 was not properly chained or supported in a proper cylinder stand or cart. #2.) Based on observation and interview, the facility failed to ensure 10 of 10 full and empty oxygen cylinders were separated and marked to avoid confusion. This deficient practice could affect up to 30 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director and Administrator on 04/05/23 at 12:30 p.m., the oxygen storage room contained full and empty oxygen cylinders, but the cylinders were mixed together and not marked as full or empty. Based on interview at the time of observation, the Maintenance Director stated the cylinders were not marked as full or empty. The findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		will be made to ensure that the deficient practice does not recur; A quality assurance tool has been developed for weekly inspection of the Oxygen storage room and resident rooms for E type cylinders. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Quality Assurance Audit Tool will be completed by the Administrator/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	
K 0927 SS=F Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155086	A. BUILDING 01 B. WING	04/05/2023

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WOODLAND MANOR	343 S NAPPANEE ST ELKHART, IN 46514

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	any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)			
	Based on records review and interview, the facility failed to ensure staff was properly trained on trans-filling procedures in 1 of 1 oxygen storage room where oxygen transferring takes place. NFPA 99 2012 edition, 11.5.2.3.1 (4) the individual trans-filling the container(s) has been properly trained in the trans-filling procedures. This deficient practice could affect up to 20 residents in one smoke compartment. Findings include: Based on records review with the Maintenance Director and Administrator on 04/05/23 at 09:00 a.m., no documentation was available for review to indicate if staff was properly trained on trans-filling liquid oxygen from stationary liquid oxygen tanks to portable liquid oxygen containers. Based on interview at the time of observation, the Administrator stated the training paperwork could not be found and will retrain staff. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0927	K927 It is the intent of the facility to maintain training of staff for transfilling of Oxygen. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Training of staff has been completed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 20 residents within the smoke compartment had a potential to be affected by the deficit practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Oxygen transfilling set on the annual in-service schedule. Quality Assurance tool for proper transfilling of Oxygen has been developed for observation 3 times a week. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Quality	06/01/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155086	A. BUILDING 01 B. WING	04/05/2023

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			Assurance Audit Tool will be completed by the Administrator/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	