STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155383	A. BUILDING -- B. WING	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WASHINGTON HEALTHCARE CENTER	8201 W WASHINGTON ST INDIANAPOLIS, IN 46231

(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: 07/29/24 Facility Number: 000393 Provider Number: 155383 AIM Number: 100289340 At this Emergency Preparedness survey, Washington Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 94 certified beds. At the time of the survey, the census was 57. Quality Review completed on 07/31/24	E 0000		
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: 07/29/24 Facility Number: 000393 Provider Number: 155383 AIM Number: 100289340 At this Life Safety Code survey, Washington	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keira Gilmore	Executive Director	08/12/2024

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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	Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 94 and had a census of 57 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached building for storage of supplies which was not sprinklered. Quality Review completed on 07/31/24			
K 0100 SS=B Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure fire resistance rating labels on 1 of 6 cross corridor door sets were not painted. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This	K 0100	**K-0100** The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or	08/16/2024

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	deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:25 p.m. on 07/29/24, the east door in the cross corridor door set by the nurse's station by the entrance to the 200 Hall was equipped with a fire resistance rating label affixed to the hinge side of the door. The fire resistance rating label was painted and was not legible. Each door in the cross corridor door set was equipped with latching hardware to latch each door into the door frame. Review of the floor plan for the facility during the tour indicated the cross corridor door set was not in a fire or smoke wall for the facility. Based on interview at the time of the observations, the Maintenance Supervisor agreed the fire resistance rating label affixed to the east door in the aforementioned cross corridor door set was painted. These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b)		of any violation of regulation. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Paint has been removed from the fire resistance label. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Building walk through will take place to ensure legibility of additional fire-resistant labeling. **What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** Building will monitor all future improvement projects to ensure that the label remains legible. **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?** To ensure compliance, the Maintenance Director /Designee will complete monthly walk throughs to ensure all fire resistance labeling remains legible. Results of the audit will be	

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			presented to the QAPI committee. If 100% is not achieved an action plan will be implemented. Paper compliance requested Date of Compliance: 8/16/2024	
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 2 of 4 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	K 0232	**K-0232** The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Furniture was removed from the corridor. The two wooden chairs outside of the nurse's station and the wooden chair outside room 109 were removed.	08/16/2024

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	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 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 over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Assistant during an initial walk through of the facility from 8:35 a.m. to 8:50 a.m. on 07/29/24, one table and two wooden chairs were stored next to one another up against the corridor wall outside the Director of Nursing Services Office and were not affixed to the floor or to the wall. In addition, one wooden chair was stored up against the corridor wall outside Room 109 and was not affixed to the floor or to the wall. Based on observations with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:25 p.m. on 07/29/24, the one table and two chairs were still stored in the corridor outside the Director of Nursing Services Office and the chair was still stored in the corridor outside Room 109. Each of the chairs and the table extended two feet into the eight foot wide corridor. Based on interview at the time of the observations, the Maintenance Supervisor agreed furniture was		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Building walk through will take place to identify any additional obstructions and removal by Maintenance/designee **What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** Daily rounds will take place to ensure that the corridor is free of obstruction by maintenance/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?** To ensure compliance, the Maintenance Director /Designee will complete weekly audits x 4 weeks and monthly thereafter for 6 months. Results of the audit will be presented to the QAPI committee. If 100% is not achieved an action plan will be implemented.	

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	stored in the corridor at the aforementioned two locations and was not affixed to the floor or to the wall. These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b)		Paper Compliance requested. Date of Compliance: 8/16/2024	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 1 door sets to the outside of the facility in the Therapy Room were not mistaken as a facility exit. LSC Section 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Therapy Room. Findings include:	K 0293	**K-0293** The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Exit sign was removed from above door outside the therapy room. **How will you identify other residents having the potential**	08/16/2024

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	Based on observations with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:25 p.m. on 07/29/24, the exit door set to the outside of the facility in the Therapy Room was marked as a facility exit with an exit sign. The door set was also equipped with signage affixed to the door set stating "Not an Exit. Based on interview at the time of the observations, the Maintenance Supervisor stated the door set is not a facility exit and agreed the door set was marked as a facility exit with an exit sign and was also marked as not an exit. These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Building walk through will take place to identify any additional exits mismarked by the Maintenance Director. **What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** Building exit signs will be monitored for accuracy, no new exits to be added. **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?** To ensure compliance, the Maintenance Director /Designee will complete monthly walk throughs to ensure all marked exits are accurate. Results of the walk through will be presented to the QAPI committee. If 100% is not achieved an action plan will be implemented. Paper compliance is requested. Date of Compliance: 8/16/2024	

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K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (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 over 12 hazardous areas such as boiler and fuel fired heater rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing	K 0321	**K-0321** The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth	08/16/2024

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	or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the boiler room. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:25 p.m. on 07/29/24, a three foot by one foot hole was noted in the ceiling of the boiler room which can be accessed from only the outside of the building. Based on interview at the time of the observations, the Maintenance Supervisor stated the facility experienced recent water leaks which damaged the ceiling in the boiler room and agreed the aforementioned hazardous area was not separated from other spaces by smoke resistant partitions and doors. These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b)		in the statement of deficiencies, or of any violation of regulation. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** The ceiling in the boiler room will be replaced and repaired to original condition separating the boiler room from other spaces using a smoke resistant partition. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Additional ceiling tiles will be examined and replaced if found to not be in good condition. **What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** ~~C~~hecks will be conducted to ensure that no additional hazards are identified. **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?** To ensure compliance, the Maintenance Director /Designee	

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			will complete weekly audits x 4 weeks and monthly thereafter for 6 months Results of the audit will be presented to the QAPI committee. If 100% is not achieved an action plan will be implemented.	
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 facility failed to ensure 1 of 1 sprinkler systems was maintained with supported spare sprinklers which can be accessed promptly. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers	K 0353	**K-0353** The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. **What corrective action(s) will**	08/16/2024

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	that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:25 p.m. on 07/29/24, the air compressor for the facility's dry sprinkler system was bolted to the floor of the sprinkler riser room near one wall of the room which blocked access to the two wall mounted spare sprinkler cabinets in the room. Based on interview at the time of the observations, the Maintenance Supervisor agreed the air compressor blocked prompt access to the spare sprinklers in the wall mounted spare sprinkler cabinets in the room. These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 ceiling smoke barriers. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and		**be taken for those residents found to have been affected by the deficient practice?** Spare sprinkler cabinets have been raised to allow for prompt access and without issue. 21 spare sprinkler heads have been ordered and will be replaced upon receipt. Hole in the boiler room and vending room has been repaired **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Room assessment will take place to ensure no additional sprinkler heads are rusted. Heads will be replaced as needed. Maintenance director inspected all ceilings to ensure in good repair. **What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** ~~Ch~~ecks will be conducted to ensure that all sprinkler heads are in good working order. Ceilings will be inspected to ensure in good repair. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	causes the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the boiler room. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:25 p.m. on 07/29/24, a three foot by one foot hole was noted in the ceiling of the boiler room which can be accessed from only the outside of the building. In addition, a two foot by eighteen inch hole was noted in the ceiling of the vending machine room near the south exit of the facility by the boiler room. Each of the two holes in the ceiling did not maintain the ceiling construction and exposed the attic above. Based on interview at the time of the observations, the Maintenance Supervisor stated the facility experienced recent water leaks which damaged the ceiling in the two rooms and agreed the holes in the ceiling at the aforementioned two locations did not maintain the ceiling construction. These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b) 3. Based on record review and interview, the facility failed to ensure 8 of over 100 sprinkler heads in the facility which were corroded were replaced in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection		**recur, i.e. what quality assurance program will be put into place?** To ensure compliance, the Maintenance Director /Designee will complete weekly audits x 4 weeks and monthly thereafter for 6 months Results of the audit will be presented to the QAPI committee. If 100% is not achieved an action plan will be implemented. Paper compliance requested. Date of Compliance: 8/16/2024	

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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
	Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect over 2 kitchen staff and visitors. Findings include: Based on review of the sprinkler system inspection contractor's "Form for Inspection, Testing and Maintenance of Dry Pipe Fire Sprinkler Systems" documentation dated 04/01/24 with the Maintenance Supervisor during record review from 9:35 a.m. to 12:50 p.m. on 07/29/24, eight sprinklers installed in the kitchen were corroded and need to be replaced. Based on interview at the time of record review, the Maintenance Supervisor stated the kitchen sprinkler heads were not replaced on or after 04/01/24. The Maintenance Supervisor stated the facility hired a different sprinkler system inspection contractor to perform the sprinkler replacements. The sprinkler system inspection			

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	155383	A. BUILDING 01 B. WING	07/29/2024

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	contractor provided a letter to the facility dated 07/29/24 at the time of the survey which stated the contractor "has received approval and will be replacing a total of 21 dry sprinkler heads throughout the building in the kitchen, mechanical room, shower room, utility and the front porch area. The sprinkler heads have been ordered and we are currently awaiting their arrival". These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b)			
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 maintain 1 of 1 portable K Class fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 5.5.5 states fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 5.5.5.3 states a placard shall be placed near the extinguisher that states that the protection system shall be actuated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using the portable fire extinguisher. In this instance, the	K 0355	**K-0355** The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Placard was replaced on wall near fire extinguisher. **How will you identify other residents having the potential**	08/16/2024

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	portable fire extinguisher is supplemental protection. This deficient practice could affect over two kitchen staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:25 p.m. on 07/29/24, one portable K Class fire extinguisher was located in the kitchen. A placard was not conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Based on interview at the time of the observations, the Maintenance Supervisor provided the placard that had been in place and stated the wall where it had been in place was recently painted, the placard was torn and needed to be replaced and agreed a placard was not conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. There are no other K fire extinguishers in the facility. **What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** Maintenance Director/designee will round weekly to ensure placard is present and conspicuously placed by the K extinguisher. **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?** To ensure compliance, the Maintenance Director /Designee will complete weekly audits x 4 weeks and monthly thereafter for 6 months. Results of the audit will be presented to the QAPI committee. If 100% is not achieved an action plan will be implemented. Paper compliance is requested	

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			Date of Compliance: 8/16/2024	
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 Based on observation and interview, the facility failed to ensure 1 of 1 therapy rooms were separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). 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 over 10 residents, staff and visitors in the vicinity of the Therapy Room. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:25 p.m. on 07/29/24, the inactive leaf in the corridor door set to the Therapy Room was not equipped with a positive latching mechanism to latch the door into the door frame when tested	K 0361	**K-0361** The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** A positive latching device was added to the therapy room door. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. All doors will be checked to ensure the latching device is present or remains closed. **What measures will be put into place or what systemic**	08/16/2024

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	to close multiple times. The inactive leaf in the door set can be secured into the door frame with flip latches at the top and the bottom of the door leaf. The flip latches had to be manually flipped in order to latch or unlatch the door into the door frame. The active leaf in the door set was equipped with a positive latching device but the latching mechanism did not protrude into the latching plate on the inactive leaf when tested to close and latch multiple times. Based on interview at the time of the observations, the Maintenance Supervisor agreed the inactive leaf in the corridor door set to the Therapy Room was not equipped with a positive latching device and the active leaf's positive latching mechanism did not secure the door into the door frame. These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**changes will you make to ensure that deficient practice does not recur?** Doors will be monitored for operational positive latching devices. **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?** To ensure compliance, the Maintenance Director /Designee will complete weekly audits x 4 weeks and monthly thereafter for 6 months Results of the audit will be presented to the QAPI committee. If 100% is not achieved an action plan will be implemented. Date of Compliance: 8/16/2024	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors			

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	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 over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include:	K 0363	**K-0363** The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. **What corrective action(s) will**	08/16/2024

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	Based on observations with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:25 p.m. on 07/29/24, the single leaf corridor door to the dining room and the corridor door to the Executive Director's office were both propped in the fully open position with a wedge placed on the floor under the door. Based on interview at the time of the observations, the Maintenance Supervisor agreed the aforementioned corridor doors each had an impediment to closing and latching into the door frame and would not resist the passage of smoke. These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**be taken for those residents found to have been affected by the deficient practice?** Doorstops were removed from both doors. A positive latching device was added to door in the dining hall. Magnetic latch to be added to door in ED office. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Building walk through to ensure no additional doors lack positive latching to resist the passage of smoke. **What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** In servicing of door stop use will be completed for all staff, by ED/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?** To ensure compliance, the Maintenance Director /Designee will complete weekly audits x 4 weeks and monthly thereafter for 6 months Results of the audit will be presented to the QAPI committee.	

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K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure receptacles in 1 of 1 Beauty Salons were properly grounded in accordance with NFPA 70. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition at 406.4 General Installation Requirements states receptacle outlets shall be located in branch circuits in accordance with Part III of Article 210. General installation requirements shall be in accordance with 406.4(A) through (F). (A) Grounding Type. Receptacles installed on 15- and 20-ampere branch circuits shall be of the grounding type. Grounding-type receptacles shall be installed only on circuits of the voltage class and current for which they are rated, except as provided in Table 210.21(B)(2) and Table 210.21(B)(3). Exception: Nongrounding-type receptacles installed in accordance with 406.4(D).	K 0511	**K-0511** The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** An electrician visit has been scheduled to repair wires in the beauty salon. Junction box cover in the attic has been replaced. Identified receptacles in the attic have a cover plate. **How will you identify other residents having the potential to be affected by the same**	08/16/2024

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	(B) To Be Grounded. Receptacles and cord connectors that have equipment grounding conductor contacts shall have those contacts connected to an equipment grounding conductor. Exception No. 1: Receptacles mounted on portable and vehicle-mounted generators in accordance with 250.34. Exception No. 2: Replacement receptacles as permitted by 406.4(D). (C) Methods of Grounding. The equipment grounding conductor contacts of receptacles and cord connectors shall be grounded by connection to the equipment grounding conductor of the circuit supplying the receptacle or cord connector. The branch-circuit wiring method shall include or provide an equipment grounding conductor to which the equipment grounding conductor contacts of the receptacle or cord connector are connected. Informational Note No. 1: See 250.118 for acceptable grounding means. Informational Note No. 2: For extensions of existing branch circuits, see 250.130. This deficient practice could affect 1 resident and staff in the Beauty Salon. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:25 p.m. on 07/29/24, GFCI receptacles in one of one outlet boxes installed on the wall of the Beauty Salon above the sink were found to have an "open ground" when tested with an Ideal Industries UL listed circuit tester testing device. Based on interview at the time of the observations, the Maintenance Supervisor agreed the testing device showed the aforementioned electrical receptacle location needed repair.		**deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. A building walk through will take place to identify any additional exposed wiring, and any electrical receptacle needing repairs/cover plates. **What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** Building walk through will be done to ensure no additional electrical hazards are present. Repairs will be made as needed. Maintenance Director/Designee will complete walkthrough in attic to ensure receptacles are in good repair after any construction, wiring, etc. **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?** To ensure compliance, the Maintenance Director /Designee will complete weekly audits x 4 weeks and monthly thereafter for 6 months Results of the audit will be presented to the QAPI committee. If 100% is not achieved an action plan will be implemented.	

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	These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 electrical junction boxes in the attic above the south attic access door was 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 over 1 staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:25 p.m. on 07/29/24, one of one electrical junction boxes installed on a wood stud in the attic above the attic access door at the south end of the building outside the Maintenance Office was without a cover which exposed the spliced electrical wiring in the junction box. Based on interview at the time of the observations, the Maintenance Supervisor agreed the aforementioned electrical junction box location did not have its cover plate installed which exposed the spliced electrical wiring in the junction box. These findings were reviewed with the Executive Director and the Maintenance Supervisor during		Date of Compliance: 8/16/2024	

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	the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of over 100 electrical fixtures were protected in accordance with LSC 19.5.1.1. NFPA 70, National Electric Code, 2011 Edition, Article 406.5, states receptacles shall be enclosed so that live wiring terminals are not exposed to contact. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect over 1 staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:25 p.m. on 07/29/24, two of two receptacles affixed to a wood stud in the attic above the attic access door by the entrance to the kitchen from the dining room was not enclosed in an outlet box with a cover plate. A portable lighting fixture was plugged into one of the receptacles. Based on interview at the time of the observations, the Maintenance Supervisor agreed the aforementioned electrical fixtures were exposed and not protected in an outlet box with a cover plate. These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b)			

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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 document activation of the fire alarm system on fire drills conducted between 6:00 a.m. and 9:00 p.m. on the second shift for 1 of 4 quarters. LSC 19.7.1.4 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Fire Drills" documentation with the Maintenance Supervisor during record review from 9:35 a.m. to 12:50 p.m. on 07/29/24, documentation for the second shift fire drills conducted on 10/30/23, 11/27/23 and 12/29/23 at, respectively, 5:05 p.m., 5:00 p.m. and 3:00 p.m. during the fourth quarter (October, November, December) 2023 indicated the drills were	K 0712	**K-0712** The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Alarm will be sounder for all fire drills not taking place between 9pm-6am. Coded announcement will only be used during designated hours. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the	08/16/2024

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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
	conducted after 6:00 a.m. but before 9:00 p.m. and did not document activation of the fire alarm system and transmission of the fire alarm signal at the time of the fire drill. The aforementioned second shift fire drill documentation stated, "silent alarm" and "NA" in response to "Was alarm received by fire department, police or by monitoring company?" Based on interview at the time of record review, the Maintenance Supervisor stated the facility operates three shifts per day, company policy requires the facility conduct a fire drill once per shift per month, additional fire drill documentation for the second shift in the fourth quarter 2023 was not available for review and agreed documentation for the aforementioned second shift fire drills conducted after 6:00 a.m. but before 9:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal at the time of the fire drill. These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b) 3.1-51(c)		alleged deficient practice. Maintenance and housekeeping staff was inserviced by ED regarding conducting of fire drills with activation of the fire alarm system during the hours of 6AM to 9 PM. ~~No additional residents were affected.~~ **What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** All housekeeping and maintenance staff will be in-serviced on fire drills and documentation in Tels by ED/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?** To ensure compliance, the Maintenance Director /Designee will complete monthly fire drill audits x 6 months. Results of the audit will be presented to the QAPI committee. If 100% is not achieved an action plan will be implemented. Paper compliance requested Date of Compliance: 8/16/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155383	A. BUILDING 01 B. WING	07/29/2024

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K 0911 SS=F Bldg. 01	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems 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. Chapter 6 (NFPA 99) Based on observation and interview, the facility failed to ensure access and working space was maintained in 2 of 2 electrical panel rooms. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A) (1), (2) and (3). 110.26(A)(1) states the depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A) (1) which the minimum clear distance is 3 feet. Article 110.26(A) (2) states the width of the working space in front of the electrical equipment shall be the width of the equipment or 762 mm (30 in.), whichever is greater. In all cases, the workspace shall permit at least a 90 degree opening of equipment doors or hinged panels. 110.26(A)(3) states the workspace shall be clear and extend from the grade, floor, or platform to a	K 0911	**K-0911** The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Items were removed from within three feet of the electrical panel in both rooms – maintenance office and electrical room. Signed indicating not a storage area added. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice.	08/16/2024

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	height of 6 and 1/2 feet or the height of the equipment, whichever is greater. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:25 p.m. on 07/29/24, two housekeeping carts were stored up against the main electrical panels for the facility in the Electrical Room by the nurse's station near the entrance to the 200 Hall. Red tape was affixed to the floor in front of the electrical panels to indicate where items should not be stored in the room, but the carts were stored within the area marked off with the tape. In addition, furniture, buckets and maintenance supplies were stored underneath and within three feet of the wall mounted electrical panels identified as Panel C and Panel E in the Maintenance Office. Based on interview at the time of the observations, the Maintenance Supervisor agreed the aforementioned items were stored within the working space in front of the electrical panels in the two rooms. These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b)		Building walk through will take place to identify any additional obstructions and removal for electrical panels.. **What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** All housekeeping and maintenance staff will be in serviced on storage away from the electrical panel. checks will be scheduled to ensure items are not placed in front of electrical panels. **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?** To ensure compliance, the Maintenance Director /Designee will complete weekly audits x 4 weeks and monthly thereafter for 6 months Results of the audit will be presented to the QAPI committee. If 100% is not achieved an action plan will be implemented. Date of Compliance: 8/16/2024	

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K 0914 SS=E 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 failed to ensure nonhospital-grade electrical receptacles that failed annual testing in 10 of over 40 resident rooms were replaced with hospital-grade receptacles. NFPA 70, The National Electrical Code, 2011 Edition, at Article 517.18(B) states each patient bed location shall be provided with a minimum of four receptacles. They shall be permitted to be of the single, duplex, or quadruplex type, or any combination of the three. All receptacles, whether four or more, shall be listed as "hospital grade" and so identified. It	K 0914	**K-0914** The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?**	08/16/2024

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	is not intended that there be a total, immediate replacement of existing non-hospital grade receptacles. It is intended, however, that non-hospital grade receptacles be replaced with hospital grade receptacles upon modification of use, renovation, or as existing receptacles need replacement. This deficient practice could affect over 10 residents. Findings include: Based on review of "Receptacle Testing" documentation dated May 2024 with the Maintenance Supervisor during record review from 9:35 a.m. to 12:50 p.m. on 07/29/24, select electrical receptacles in outlet boxes in ten resident sleeping rooms failed annual inspection and testing. Each of the receptacles which failed annual inspection and testing were listed as failing due to "Ground Retention > 4 ounces". The select receptacle outlet boxes in resident sleeping rooms identified in the May 2024 testing as failing were located in: a. Room 101, outlet box #3. b. Room 103, outlet box #2. c. Room 108, outlet box #2. d. Room 203, outlet box #2. e. Room 208, outlet box #4. f. Room 301, outlet box #3. g. Room 302, outlet box #2. h. Room 309, outlet box #1 and outlet box #2. i. Room 310, outlet box # 3. j. Room 313, outlet box #1. Based on interview at the time of record review, the Maintenance Supervisor stated non-hospital grade electrical receptacles are currently installed in resident sleeping rooms and stated the receptacles which failed May 2024 testing have not yet been replaced.		Replacements will be made to hospital grade receptacles. Receptacles have been ordered and will be replaced upon receipt for the following rooms – Room 101, outlet box#3, Room 103, outlet box #2, Room 108, outlet box #2, Room 203 outlet box #2, Room 208 outlet box #4, Room 301 outlet box #3, Room 302, outlet box #2, Room 309 outlet box #1 and box #2, Room 310 outlet box #3, and Room 313 outlet box #1. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Outlet testing will be conducted to ensure outlet are hospital grade receptacles. **What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** Regular outlet testing will take place to ensure outlets are hospital grade receptacles by Maintenance Director **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?**	

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	These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b)		To ensure compliance, the Maintenance Director /Designee will complete weekly audits x 4 weeks and monthly thereafter for 6 months Results of the audit will be presented to the QAPI committee. If 100% is not achieved an action plan will be implemented. Paper compliance requested. Date of Compliance: 8/16/2024	