STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155277	A. BUILDING -- B. WING	07/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE VALPARAISO	3301 N CALUMET AVE VALPARAISO, IN 46383

(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 State Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/05/18 Facility Number: 000176 Provider Number: 155277 AIM Number: 100288940 At this Emergency Preparedness survey, Aperion Care Valparaiso, was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 150 certified beds. At the time of the survey, the census was 82. Quality Review completed on 07/09/18 - DA The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0006 SS=C Bldg. --	Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance	E 0006	**E 006** **I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No resident was found to be affected by the finding. **II. how other residents having**	08/04/2018

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

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	with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants. Findings include: During record review with the Executive Director on 07/05/18 at 10:48 a.m. no documentation could be located indicating a facility and community-based all-hazards vulnerability analysis had been completed. Based on interview at the time of record review, the Executive Director agreed that a facility and community-based all-hazards vulnerability analysis had not been completed.		**the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by the finding. **III. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Facility Risk Assessment that was previously completed was placed in the facility Emergency Operations Plan binder. **IV. 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 facility Administrator will review the Facility Risk Assessment at next QAPI Meeting to ensure completion and compliance. **V. by what date the systemic changes for each deficiency will be completed:** 8/4/18	
E 0024 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for	E 0024	**E 024** **I. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	08/04/2018

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E 0026 SS=C Bldg. --	integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect all occupants. Findings include: During record review with the Executive Director on 07/05/18 at 10:59 a.m., no documentation could be located regarding the use or integration of volunteers in the event of an emergency. This includes non-medical volunteers, medically-trained volunteers, and States or Federally designated professionals. During interview at the time of record, the Executive Director acknowledged that a policy regarding volunteers or emergency staffing was unavailable.	E 0026	No resident was found to be affected by the finding. **II. 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 have the potential to be affected by the finding. **III. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The facility has a written policy for use of volunteers in an emergency, which has been included in the Emergency Operations Plan. **IV. 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 facility Administrator will present the policy for utilizing volunteers during an emergency to the QAPI Committee during next QAPI Meeting to ensure completion and compliance. **V. by what date the systemic changes for each deficiency will be completed:** 8/4/18 **E 026**	08/04/2018

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	Based on record review and interview, the facility failed to develop policies and procedures of the role of the facility under a waiver declared by the Secretary of Health and Human Services, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials, as required by 42 CFR 483.73(b)(8). This deficient practice could affect all residents, staff, and visitors. Findings include: During record review with the Executive Director on 07/05/18 at 10:59 a.m. no documentation of policies and procedures of the role of the facility under a waiver declared by the Secretary of Health and Human Services, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials could be located. Based on interview at the time of record review, the Executive Director wase unaware of the 1135 waiver, and confirmed that there was no policy in place.		**I. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No resident was found to be affected by the finding. **II. 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 have the potential to be affected by the finding. **III. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The facility has included a policy of 1135 Waiver in the event of a declared emergency into its Emergency Operations Plan. **IV. 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 facility Administrator will present the 1135 Waiver policy to the QAPI Committee during the next QAPI Meeting to ensure completion and compliance. **V. by what date the systemic changes for each deficiency will be completed:** 8/4/18	

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E 0039 SS=C Bldg. --	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: During record review with the Executive Director on 07/05/18 at 11:05 a.m. no documentation could be provided indicating the facility had conducted a full-scale exercise or a table-top exercise. Based	E 0039	**E 039** **I. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No resident was found to be affected by the finding. **II. 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 have the potential to be affected by the finding. **III. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The facility was able to locate documentation of participation in a full scale emergency exercise of an Evacuation and Active Shooter situation on 11/21/17 and documentation was placed in the EP binder. **IV. 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 facility Administrator will present the located documentation to the QAPI Committee during	08/04/2018

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	on interview at the time of record review, the Executive Director stated that drills had been conducted prior to his arrival, however he could not locate or provide any documentation to include a scenario or after-action reports.		next QAPI Meeting to ensure completion and compliance. **V. by what date the systemic changes for each deficiency will be completed:** 8/4/18	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/05/18 Facility Number: 000176 Provider Number: 155277 AIM Number: 100288940 At this Life Safety Code survey, Aperion Care Valparaiso 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 facility is located in two, two story buildings with walk out lower levels and connected by the "tunnel", a one story corridor. The two buildings, identified as the Pines and the Manor were determined to be of Type II (111) construction, built prior to March 1, 2003 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 resident sleeping Rooms #1 through #37 on the Pines upper level and hard	K 0000		

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	wired smoke detectors supervised by the fire alarm system in rooms 38 through 43 on the Pines lower level. Smoke detectors in resident sleeping rooms on the upper and lower level are hard wired. The facility has the capacity for 150 and had a census of 82 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 07/09/18 - DA			
K 0222 SS=D 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 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			

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	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 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	K 0222	**K 222** **I. what corrective action(s) will**	08/04/2018

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	failed to ensure the means of egress through 1 of 5 exits were readily accessible. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over staff and visitors only. Findings include: Based on observations with the Executive Director and Maintenance Director during a tour of the facility on 07/05/18 at 12:27 p.m., the exit door at the east side of the connecting corridor was marked as a facility exit, was magnetically locked and could be opened by entering a four digit code but the code was not posted at the exit. Based on interview at the time of the observations, the Executive Director and Maintenance Director stated residents with a clinical diagnosis requiring specialized security measures are housed in a different area and acknowledged the aforementioned facility exit was marked as a facility exit and could be opened by entering a four digit code but the code was not posted. 3.1-19(b)		**be accomplished for those residents found to have been affected by the deficient practice;** No resident was found to be affected by the finding. **II. 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 have the potential to be affected by the finding. The door code has been posted on the key pad of the door at the east side of the connecting corridor. **III. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Maintenance Director will audit each coded door monthly to ensure the exit code is posted on/near the key pad. Audits will be performed on an ongoing basis. **IV. 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;** Results of the exit door code posting will be presented to the QAPI Committee during monthly QAPI Meetings for 3 months to ensure completion. **V. by what date the systemic changes for each deficiency**	

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			will be completed: 8/4/18	
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) 1) Based on observation and interview, the facility failed to ensure the corridor door to 3 of over 10	K 0321	**K 321** **I. what corrective action(s) will be accomplished for those**	08/04/2018

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	hazardous areas, such as combustible storage room over 50 square feet and fuel-fired equipment rooms, were separated from other spaces by smoke resistant partitions and doors in accordance withe LSC 7.2.1.8. This deficient practice could affect staff only in the un-used Upper Pines South Wing and staff, visitors and up to 5 residents in the Lobby/Administration smoke compartment. Findings include: During a tour with the Executive Director and the Maintenance Director on 07/05/18 the following conditions were found: a) At 12:50 p.m. it was found that Room 25 had combustible storage, including more than 10 cardboard boxes, however did not have a self-closing device. b) At 12:51 p.m. it was found that Room 31 also had combustible storage, including several boxes of holiday decorations, and did not have a self-closing device. c) At 11:50 p.m. there was a 2 inch by 4 inch penetration around wires in the barrier around the Lower Level Manor boiler room. Based on interview at the time of each observation, the Executive Director and the Maintenance Director agreed that the rooms contained combustible storage or fuel-fired quipment and did not have the required protections. 3.1-19(b) 2) Based on observation and interview, the facility failed to ensure 1 of 3 hazardous areas such as fuel-fired equipment rooms were separated from other spaces by smoke resistant partitions and doors in accordance with This deficient practice		**residents found to have been affected by the deficient practice;** No resident was found to have a negative outcome as a result of the finding. **II. 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 on the Upper Pines unit have the potential to be affected by the finding. Rooms 25 and 31 will have self-closing devices installed on the doors by 8/4/18. The 2 inch by 4 inch penetration around wires in the barrier around the lower level Manor boiler room will be repaired by 8/4/18. The door to the soiled utility room across the hall from the North Hall nurse's station will be repaired to ensure it closes and latches by 8/4/18. **III. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Maintenance Director/designee will complete audits of 5 random storage rooms/boiler rooms/utility rooms to ensure areas have proper functioning door closer devices and free of barrier penetrations. Audits will be ongoing.	

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	could affect 20 residents, staff and visitors in the vicinity of the Soiled Utility room near the North Hall nurse's station. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:25 a.m. to 1:40 p.m. on 02/16/17, the corridor door to the Soiled Utility room across the hall from the North Hall nurse's station was equipped with a self-closing device but the door failed to fully close and latch into the door frame when tested three separate times. When swinging to close, the door bounced off the door jamb on the latching side and left a one inch gap between the door and the door jamb on the latching side of the door. Based on interview at the time of observation, the Maintenance Director acknowledged the corridor door to the aforementioned hazardous area failed to self-close and latch into the door frame. 3.1-19(b)		**IV. 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 Maintenance Director/designee will present findings of audits to the QAPI Committee during monthly QAPI Meeting for 3 months to ensure completion and compliance. **V. by what date the systemic changes for each deficiency will be completed:** 8/4/18	
K 0353 SS=C 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			

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	Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 2 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the quarterly sprinkler system inspection records on 07/05/18 at 11:12 a.m. with	K 0353	**K 353** **I. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No resident was found to be affected by the finding. **II. 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 have the potential to be affected by the finding. Missing documentation of the 2 quarterly sprinkler inspections was obtained from vendor. Sprinkler inspection was completed 7/19/18. **III. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Maintenance Director/designee will ensure quarterly sprinkler inspections are completed and documentation of inspection is obtained from the vendor. **IV. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	08/04/2018

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	the Maintenance Director and Executive Director present, there was no quarterly sprinkler system inspection report available for the first (January, February, and March) and second quarters (April, May, June) of 2018. During an interview at the time of record review, the Maintenance Director stated that inspections had been completed, however he was unable to provide any documentation. 3.1-19(b)		**assurance program will be put into place;** The Maintenance Director/designee will present the next 2 quarterly sprinkler inspections to the QAPI Committee during QAPI Meetings to ensure completion and compliance. **V. by what date the systemic changes for each deficiency will be completed**. 8/4/18	
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping 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			

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	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 more than 80 room doors to the corridor were maintained in accordance with LSC Section 19.3.6.3. Section 19.3.6.3.5 states that corridor doors shall be provided with a means for keeping the door closed. This deficient practice could affect staff and up to 5 residents in the Manor Lower South smoke compartment and up to 8 residents in the Manor Upper South smoke compartment. Findings include: Based on observation on 07/05/18 during a tour of the facility with the Executive Director and Maintenance Director the following was found: a) At 11:40 a.m. resident room 172 failed to latch after 3 attempts. b) At 12:20 p.m. resident room 277 failed to latch after 3 attempts Based on interview at the time of each observation, the Executive Director and the Maintenance Director agreed that the corridor	K 0363	**K 363** **I. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were found to have a negative outcome as a result of the finding. **II. 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 have the potential to be affected by the finding. **III. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The doors to rooms 172 and 277 will be repaired by 8/4/18.	08/04/2018

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	doors did not latch at the time of observation. 3.1-19(b)		The Maintenance Director/designee will check 5 random doors monthly to ensure the doors close and latch properly. Audits will be ongoing. **IV. 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 Maintenance Director/designee will present the findings of the door latching audits to the QAPI Committee during Monthly QAPI Meetings for 3 months to ensure completion. **V. by what date the systemic changes for each deficiency will be completed:** 8/4/18	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. 1. Based on observation and interview, the facility	K 0372	**K 372** **I. what corrective action(s) will**	08/04/2018

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	failed to ensure the penetrations caused by the passage of wire and/or conduit through 2 of 6 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect staff and at least 69 residents. Findings include: During a tour of the facility with the Maintenance Director on 07/05/18 the following conditions were found: a) At 1:30 p.m. a one inch by two inch penetration around pipe was located above the ceiling tile in the Manor Lobby/Office smoke barrier. b) At 1:35 p.m. a four inch by ten inch penetration was located around pipe in the Manor dining/Room 167 barrier. Based on interview at the time of each observation, the Maintenance Director agreed there were penetrations in the smoke barriers and provided the measurements. 3.1-19(b) 2. Based on record review, observation and interview, the facility failed to maintain at least 1 of 1 smoke damper per 8.5.5.4.2. LSC 8.5.5.4.2 requires smoke dampers and the combination smoke and fire dampers shall be inspected, tested, and maintained in accordance with 2010 edition of NFPA 105. NFPA 105 6.5.2 states each damper shall be tested and inspected on year after installation. The test frequency shall then be every 4 years. This deficient practice could affect staff and up to 32 residents.		**be accomplished for those residents found to have been affected by the deficient practice;** No resident was found to have a negative outcome as a result of the finding. **II. 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 have the potential to be affected by the finding. The identified penetrations in the smoke barriers will be repaired by 8/4/18. The dampers will be inspected and documentation of the inspection will be obtained from vendor. **III. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Maintenance Director/designee will observe 5 random smoke barriers monthly to ensure there are no penetrations. Audits will be ongoing. The Maintenance Director/designee will ensure annual inspections are completed on all smoke dampers. **IV. 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**	

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	Findings include: Based on observations with the Executive Director and the Maintenance Director on 07/05/18 at 10:28 a.m., no damper inspections could be provided by the facility. During a tour of the facility, dampers were located in the facility. Based on interview at the time of record review and observation, the Maintenance Director confirmed there were dampers in the building, and that he was unable to locate or provide documentation of inspection. 3.1-19(b)		**into place;** The Maintenance Director/designee will present the findings of the smoke barrier audits to the QAPI Committee during Monthly QAPI Meetings for 3 months to ensure completion. **V. by what date the systemic changes for each deficiency will be completed**: 8/4/18	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 6 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close	K 0374	**K 374** **I. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No resident was found to have a	08/04/2018

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	the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect staff and up of 25 residents in the Memory Care dining room and Manor Lower south smoke compartment. Findings include: During a tour of the facility with the Executive Director and Maintenance Director on 07/05/18, the following conditions were found: a) At 12:13 p.m. the barrier doors of the Memory Care dining room did not latch due to a faulty door coordinator. When closed, there was a two inch gap between the door leaves. b) At 11:15 a.m. the barrier door of the Lobby/Rehab barrier had 17 unsealed screw holes and an unsealed 1/2 inch bolt hole from prior door hardware. Based on interview during the time of observations, the Executive Director and Maintenance Director acknowledged the smoke barrier doors would not resist the passage of smoke due to unsealed penetrations and a faulty coordinator. 3.1-19(b)		negative outcome as a result of the finding. **II. 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;** Any resident residing on the Memory Care Unit has the potential to be affected. The barrier door coordinator on the Memory Care dining room door will be replaced by 8/4/18, therefore, eliminating the 2 inch gap. The Lobby/Rehab unit barrier door unsealed screw and bolt holes have been sealed. **III. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Maintenance Director/designee will conduct monthly random audits of 2 barrier doors to ensure proper function and integrity of doors. **IV. 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 Maintenance Director/designee will present the findings of the barrier door audits to the QAPI Committee during monthly QAPI Meetings for three months to ensure completion.	

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			V. by what date the systemic changes for each deficiency will be completed: 8/4/18	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly first shift fire drills for 1 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review of the "Fire Drill Report" form with the Maintenance Director and the Executive Director on 07/05/18 at 9:53 a.m., there was no documentation for a first shift fire drill in the second quarter of 2018. The listed drill ocurred during the second shift. Based on interview at the time of record review, the Maintenance Director and the Executive Director agreed that the scheduled first shift fire drill ocurred after first shift employees had left.	K 0712	**K 712** **I. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No resident was found to have a negative outcome as a result of the finding. **II. 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 have the potential to be affected by the finding. The Maintenance Director was re-educated on time frames of fire drill completion. **III. what measures will be put**	08/04/2018

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	3.1-19(b) 3.1-51(c)		**into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Administrator/designee will audit monthly fire drills for six months to ensure fire drills are being completed on each shift each quarter. **IV. 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 Administrator/designee will present the findings of the fire drill audits to the QAPI Committee during monthly QAPI Meetings to ensure completion and compliance. **V. by what date the systemic changes for each deficiency will be completed:** 8/4/18	
K 0761 SS=E Bldg. 01	Based on record review, observation, and interview; the facility failed to provide inspection and testing documentation for at least 1 of 1 fire door assemblies in accordance with NFPA 101, Life Safety Code 19.1.1.4.1.1. LSC 19.1.1.4.1.1 states that 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 states that openings required to have a fire protection rating	K 0761	**K 761** **I. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No resident was found to be affected by the finding. **II. how other residents having the potential to be affected by the same deficient practice will be identified and what**	08/04/2018

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	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 that 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. This deficient practice can affect all building occupants. Findings include: Based on record review with the Executive Director and the Maintenance Director from 9:30 a.m. to 11:13 a.m. on June 1, 2018, inspection and testing documentation for fire door assemblies within the most recent twelve month period was not available for review. Based on observation with the Director of Maintenance during a tour of the facility from 11:13 a.m. to 1:45 p.m. fire door assemblies were located in the facility. Based on interview at the time of record review and observation, the Maintenance Director acknowledged inspection and testing documentation for fire door assemblies for the most recent twelve month period was not available for review. 3.1-19(b)		**corrective action(s) will be taken;** All residents have the potential to be affected by the finding. An outside vendor has been contacted to complete inspection of fire door assemblies and provide the facility with documentation of inspection by 8/4/18. **III. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Maintenance Director/designee will present the fire door inspection documentation to the QAPI Committee during the first QAPI Meeting following the completion of the inspection to ensure completion and compliance. The Maintenance Director/designee will conduct monthly random audits of 2 fire doors to ensure proper function and integrity of doors. **IV. 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 Maintenance Director/designee will present the findings of the fire door inspection audits to the QAPI Committee during monthly QAPI Meetings for three months to ensure completion.	

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			V. by what date the systemic changes for each deficiency will be completed: 8/4/18	