STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155494	A. BUILDING -- B. WING	10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF SCOTTSBURG, THE	1350 N TODD DR SCOTTSBURG, IN 47170

(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: 10/25/18 Facility Number: 000478 Provider Number: 155494 AIM Number: 100290430 At this Emergency Preparedness survey, The Waters of Scottsburg was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 99 certified beds. At the time of the survey, the census was 69. Quality Review completed on 11/01/18 - DA The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. We respectfully request Desk Review. Date of compliance is November 24 2018**	
E 0034 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.73(c)(7). This deficient practice could affect all occupants.	E 0034	**E034** – It is the intent of the facility to insure the emergency preparedness communication plan includes a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction, the incident command center, or	11/24/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	Findings include: Based on record review with the Administrator and the Maintenance Director on 10/25/18 at 12:36 p.m., a communication plan that included a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.73(c)(7) was not available for review. Based on interview at the time of record review then again at the exit conference, the Administrator and the Maintenance Director confirmed that the communication plan did not include the aforementioned occupancy, needs, and ability to provide assistance to the AHJ, IC, or designee.		designee to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 11-14-18 the Administrator and Maintenance Supervisor/designee incorporated into the -Emergency Preparedness Manual a means of providing information about the facility's occupancy, needs, and ability to provide assistance to the authority having jurisdiction, incident command center or designee to meet set standards. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. The facility has only one Emergency Preparedness Manual. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 11-16-18 the Administrator in serviced the Maintenance Supervisor/designee and all staff on the requirement that the Emergency Preparedness Manual contain documentation regarding a means of providing information about the facility's occupancy, needs, and ability to provide assistance to the authority having jurisdiction, incident command center or designee to meet set standards. 2.On 11-16-18 the Administrator and Maintenance Supervisor/designee inserviced all staff on the revised Emergency	

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			Preparedness Policy Manual. 3.The Administrator and Maintenance Supervisor/designee will review the Emergency Preparedness Manual at least annually as a part of the Emergency Preparedness Program and update the Manual as appropriate. If any issues are discovered, they will be addressed and resolved immediately. 4.The Administrator will monitor adherence to the Emergency Preparedness Manual and validate documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The results will be presented by the Maintenance Supervisor/designee to the Administrator at least annually and the Administrator will present the results at the Quality Assurance/Performance Improvement (QA/PI) meeting. Results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11-24-18.**	

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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: Based on record review with the Administrator and the Maintenance Director on 10/25/18 at 12:16 p.m., the facility only performed one exercise. Based on interview at the time of record review, the Administrator and the Maintenance Director	E 0039	**E039** – It is the intent of the facility to insure to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 11-14-18 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that the facility conduct table top drills and participate in a full-scale community-based exercise annually and document that participation to meet set standards. 2.On 11-16-18 the Administrator and Environmental Supervisor/designee conducted an in-house table top exercise and a full-scale exercise to meet set standard **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.Administrator and Environmental Supervisor/designee will conduct the emergency preparedness plan tests at least annually to meet set standards. If any issues are	11/24/2018

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	confirmed a second exercise has not been performed.		discovered, they will be addressed and resolved immediately. 2.On 11-16-18 the Administrator and Maintenance Supervisor/designee inserviced all staff on the revised Emergency Preparedness Policy Manual. 3.The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The results will be presented by the Maintenance Supervisor/designee to the Administrator at least annually and the Administrator will present the results at the Quality Assurance/Performance Improvement (QA/PI) meeting. Results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11-24-18.**	
K 0000 Bldg. 01				

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	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: 10/25/18 Facility Number: 000478 Provider Number: 155494 AIM Number: 100290430 At this Life Safety Code survey, The Waters of Scottsburg was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The building was surveyed with Chapter 19 Existing Health Care Occupancies. This one story facility was determined to be of Type V (000) construction and was fully sprinkled. The facility has a fire alarm system with smoke detection in corridors and areas open to the corridor, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 99 and had a census of 69 at the time of this survey. All areas where the residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 11/01/18 - DA	K 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. We respectfully request Desk Review. Date of compliance is November 24 2018**	
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC			

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	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 maintain latching hardware on 1 of 6 smoke barrier doors per 4.6.12.3. 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 deficient practice could affect staff and up to 12 residents. Findings include: Based on observation with the Administrator and the Maintenance Director on 10/25/18 at 1:11 p.m., the Eagle Court smoke barrier doors contained latching hardware. When tested, one of the smoke barrier doors failed to latch. Based on interview at the time of observation, the Administrator and the Maintenance Director confirmed one of the two smoke barriers doors failed to latch. 3.1-19(b)	K 0100	**K100** – It is the intent of the facility to insure to maintain latching hardware on smoke barrier doors to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 10-25-18 the Maintenance Supervisor/designee repaired the latching hardware on the Eagle Court smoke barrier doors to latch completely to meet set standards. The Administrator verified the repairs on **11-12-18.** **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. On 11-14-18 the Maintenance Supervisor/designee inspected the latching hardware on all smoke barrier doors throughout the facility and found no other negative findings. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 10-25-18 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that smoke barrier doors latch completely to meet set standards.	11/24/2018

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			2.Maintenance Supervisor/designee will inspect the latching hardware on all smoke barrier doors throughout the facility monthly as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with**	

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			all regulatory requirements. Our date of compliance is 11-24-18.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to maintain 2 of 3 corridors from obstructions per 19.2.1 LSC 19.2.1 states that every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. LSC 7.1.10. Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. LSC 7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits or their access thereto, egress therefrom, or visibility thereof. This deficient practice could affect staff and at least 20 residents. Findings include: Based on observation with the Administrator and the Maintenance Director on 10/25/18 between 1:09 p.m. and 2:21 p.m., a table and a Halloween decoration was in the corridor near the Ambulance exit. Then again, a dresser was in the corridor outside of resident room 146. Based on	K 0211	**K211** – It is the intent of the facility to insure to maintain corridors free of obstructions to allow full use of the means of egress access corridors to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 10-25-18 the Maintenance Supervisor/designee removed the table and Halloween decoration from the corridor near the ambulance exit and removed the dresser from the corridor outside Room #146 to meet set standards. The Administrator verified the removal on 10-25-18. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. On 11-14-18 the Maintenance	11/24/2018

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	interview at the time of each observation, the Administrator and the Maintenance Director acknowledged that impediments such as the portable table, decoration, and dresser were potential impediments to full use of the means of egress access corridors. 3.1-19(b)		Supervisor/designee inspected all corridors throughout the facility for obstructions and found no other negative findings. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 11-16-18 the Administrator and Maintenance Supervisor/designee inserviced all staff on the requirement that corridors remain free of obstructions to meet set standards. 2.Maintenance Supervisor/designee will inspect all corridors throughout the facility for obstructions weekly as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly	

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			Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11-24-18.**	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS			

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	Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler			

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	system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the facility failed to ensure 2 of 2 smoke barrier exits had a code posted for locking devices that did not require special knowledge to open. LSC 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. LSC 7.2.1.5.3 Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. This deficient practice could affect staff and at least 12 residents. Findings include: Based on observation with the Administrator and the Maintenance Director on 10/25/18 at 12:55 p.m. then again at 1:11 p.m., the Front Entrance smoke barrier exit door then again the Eagle Court smoke barrier exit door was equipped with an electronic keypad entry system that allowed staff to open the locked exit door with a combination. No code was provided for each keypad. Based on an interview at the time of each observation, the Administrator and the Maintenance Director acknowledged no code was posted for each keypad. 3.1-19(b)	K 0222	**K222** – It is the intent of the facility to insure smoke barrier exits have a code posted for locking devices that do not require special knowledge to open to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 11-14-18 the Maintenance Supervisor/designee posted the code to unlock the exit doors at the Front Entrance smoke barrier exit door and the Eagle Court smoke barrier exit door to meet set standards. The Administrator verified the posting on 11-14-18 . **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. The facility has only 2 smoke barrier exits. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 11-14-18 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that smoke barrier exit doors equipped with electronic keypad entry systems have codes posted at the door to meet set standards. 2.Maintenance Supervisor/designee will inspect all smoke barrier exit doors equipped with electronic keypad	11/24/2018

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WATERS OF SCOTTSBURG, THE	1350 N TODD DR SCOTTSBURG, IN 47170

(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
			entry systems weekly to insure the posted code is still posted and legible as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is**	

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			11-24-18.	
K 0232 SS=D 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 1 of 3 corridors clear width requirement exception per 19.2.3.4(5). LSC 19.2.3.4(5) requires where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture. LSC 19.2.3.4(5)(a) the fixed furniture is securely attached to the floor or to the wall. This deficient practice could affect staff and up to 4 residents. Findings include: Based on observation with the Administrator and the Maintenance Director on 10/25/18 at 12:51 p.m., a chair was located in the corridor outside of Therapy. When tested, the chair was able to be moved around the corridor. Based on interview at the time of each observation, the Administrator and the Maintenance Director acknowledged the chair was not secured to the floor or wall. 3.1-19(b)	K 0232	**K232** – It is the intent of the facility to insure to meet the corridor clear width requirement to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 10-25-18 the Maintenance Supervisor/designee removed the chair located in the corridor outside of Therapy to meet set standards. The Administrator verified the removal on 10-25-18. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. On 11-16-18 the Maintenance Supervisor/designee inspected all corridors throughout the facility to insure they met the clear width requirement and found no other negative findings. **3.MEASURES TO PREVENT REOCCURRENCE**:	11/24/2018

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			1.On 11-16-18 the Administrator and Maintenance Supervisor/designee inserviced all staff that the corridors remain clear to meet the clear width requirement to meet set standards. 2.Maintenance Supervisor/designee will inspect all corridors throughout the facility weekly to insure they meet the clear width requirement as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with	

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			subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11-24-18.**	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review and interview, the facility failed to ensure documentation for the preventative maintenance of 50 of 54 battery operated smoke alarms in resident rooms was complete. NFPA 72 14.2.1.1.1 states to ensure operations integrity, the system shall have an inspection, testing, and maintenance program. NFPA 72 29.10 states fire-warning equipment shall be maintained and tested in accordance with manufacturer's published instructions and per the requirements of Chapter 14. This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator and the Maintenance Director on 10/25/18 at 12:32 p.m., the battery operated smoke alarm	K 0300	**K300** – It is the intent of the facility to insure documentation for the preventive maintenance on battery operated smoke alarms in resident rooms is completed to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.By 11-23-18 the Maintenance Supervisor/designee replaced the batteries on 50 smoke alarms to meet set standards. The Administrator verified the replacement on 11-23-18 **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff	11/24/2018

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	maintenance documentation failed to indicate smoke alarm and/or battery replacement for fifty of fifty four smoke alarms. Based on interview at the time of record review, the Administrator and the Maintenance Director confirmed the smoke detectors contain a 10 year batteries that were installed before he was hired and was unaware of when fifty smoke alarms are due for a battery change. 3.1-19(b)		and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 11-14-18 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that battery-operated smoke alarm be tested monthly and documented on the Battery-Operated Smoke Detector Maintenance Log to meet set standards. 2.Maintenance Supervisor/designee will test the battery-operated smoke alarms monthly and document those findings on the Battery-Operated Smoke Detector Maintenance Log as a part of the facility's Preventive Maintenance Program. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the	

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			inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11-24-18.**	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not			

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	be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchen. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect staff only. Findings include: Based on observation with the Administrator and the Maintenance Director on 10/25/18 at 1:29 p.m., the Kitchen contained a UL 300 hood system. Based on interview, Cook #1 was asked what he would do if there was a grease fire underneath the hood. He replied he would grab the K class fire extinguisher first. He failed to indicate pulling the hood pull station. Based on interview, the Maintenance Director acknowledged his response. 3.1-19(b)	K 0324	**K324** – It is the intent of the facility to insure staff are instructed in the use of the UL 300 hood system in the Kitchen to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 11-14-18 the Administrator and Maintenance Supervisor/designee inserviced all Kitchen staff on the procedures to follow in the event of a grease fire underneath the hood including pulling the hood pull station to meet set standards. 2.On 11-13-18 the Maintenance Supervisor/designee insured instructions for manually operating the fire extinguishing system were posted conspicuously in the Kitchen to meet set standards. **1.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. The facility has only one Kitchen hood system. **2.MEASURES TO PREVENT REOCCURRENCE**: 1.Maintenance Supervisor/designee will insure instructions for manually operating the fire extinguishing system are posted conspicuously in the Kitchen and review those	11/24/2018

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			instructions with Kitchen staff monthly as a part of the facility's Preventive Maintenance Program and document those results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 2.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **3.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11-24-18.**	

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K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping 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			

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	Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to maintain protection of corridor doors in 1 of 3 corridors in accordance of 19.3.6.3. This deficient practice could affect staff and up to 3 residents. Findings include: Based on observation with the Administrator and the Maintenance Director on 10/25/18 at 1:59 p.m., the Receptionist office contained a door stop. Based on interview at the time of observation, the Administrator and the Maintenance Director confirmed and removed the door stop. 3.1-19(b)	K 0363	**K363** – It is the intent of the facility to insure protection of corridor doors to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 10-25-18 the Maintenance Supervisor/designee removed the door stop from the Receptionist office to meet set standards. The Administrator verified the removal on 10-25-18. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. On 11-14-18 the Maintenance Supervisor/designee inspected all doors throughout the facility for door stops and found no other negative findings. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 11-16-18 the Administrator and Maintenance Supervisor/designee inserviced all staff on the requirement that door stops of any kind are prohibited from use throughout the facility to meet set standards. 2.Maintenance Supervisor/designee will inspect all doors throughout the facility for door stops of any kind monthly as a part of the facility's Preventive	11/24/2018

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			Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11-24-18.**	

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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.			
	Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 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 20 residents. Findings include: Based on observations with the Administrator and the Maintenance Director on 10/25/18 at 2:21 p.m., a two and a half inch gap around sprinkler pipe in the attic smoke barrier near resident room 141. Based on interview at the time of observation, the Administrator and the Maintenance Director acknowledged the penetration and provided the measurement. 3.1-19(b)	K 0372	**K372** – It is the intent of the facility to insure penetrations through smoke barrier walls are protected to maintain the smoke resistance of each smoke barrier to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 11-6-18 the Maintenance Supervisor/designee used a fire-resistant material to seal the penetration around the sprinkler pipe in the attic smoke barrier near Room #141 to meet set standards. The Administrator verified the sealing on 11-12-18. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. On 11-14-18 the Maintenance	11/24/2018

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			Supervisor/designee inspected all smoke barrier walls for penetrations and found no other negative findings. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.Maintenance Supervisor/designee will inspect all smoke barrier walls throughout the facility monthly for penetrations as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 2.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction	

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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 self-close. This deficient practice could affect staff and up to 8 residents. Findings include: Based on observation with the Administrator and the Maintenance Director on 10/25/18 at 12:56 p.m., the Warrior Avenue smoke barrier was impeded with a blood pressure cuff machine on	K 0374	**K374** – It is the intent of the facility to insure smoke barrier doors self-close to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 10-25-18 the Maintenance Supervisor/designee removed the blood pressure cuff machine impeding the closing of the smoke barrier door on Warrior	11/24/2018

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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
	wheels that was plugged into the wall. Based on interview at the time of observation, the Maintenance Director confirmed the door was impeded and immediately removed the blood pressure cuff machine so the doors could be tested. 3.1-19(b)		Avenue to meet set standards. The Administrator verified the removal on 10-25-18. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. On 11-14-18 the Maintenance Supervisor/designee checked all other smoke barrier doors to insure they self-closed and found no other negative findings. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 11-16-18 the Administrator and Maintenance Supervisor/designee inserviced all staff on the requirement that smoke barrier doors be free of impediments and are free to self-close to meet set standards. 2.Maintenance Supervisor/designee will inspect all smoke barrier doors throughout the facility to insure they self-close monthly as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the	

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	155494	A. BUILDING 01 B. WING	10/25/2018

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			Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11-24-18.**	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics),			

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	except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure 1 of 1 multiplug and 3 of 3 flexible cords were not used as a substitute for fixed wiring according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 11 residents. Findings include: Based on observation with the Administrator and the Maintenance Director on 10/25/18 between 12:47 p.m. and 2:01 p.m., the following was discovered: a) a surge protector was powering a refrigerator in the Administrator's office. Additionally, a surge protector was powering a microwave. b) a multiplug adapter was powering a radio in resident room 112 c) a surge protector was powering a coffee pot in the MDS office	K 0920	**K920** – It is the intent of the facility to insure multiplugs and flexible cords are not used as substitutes for fixed wiring to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 11-14-18 the Maintenance Supervisor/designee removed surge protectors from the Administrator's office and the MDS office and removed the multiplug adapter from Room #112 to meet set standards. The Administrator verified the removals on 11-14-18 2.On 11-14-18 the Maintenance Supervisor/designee installed a ground fault circuit interrupter (GFCI) in the bathroom of Room #107 to meet set standards. The Administrator verified the installation on 11-14-18. **2.ALL OTHERS WITH**	11/24/2018

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	Based on interview at the time of each observation, the Administrator and the Maintenance Director acknowledged and confirmed each wiring violation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 Resident room 107 bathroom was provided with a ground fault circuit interrupter (GFCI) protection against electric shock. LSC sections 9.1.2 requires all electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, Article 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, in 210.8(A), Dwelling Units, requires ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms and kitchens where the receptacles are intended to serve the countertop surfaces. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff and 8 residents. Findings include: Based on observation with the Administrator and the Maintenance Director on 10/25/18 at 1:03 p.m., resident room 107 bathroom receptacle was within three feet of the hand sink. The receptacle tested indicated there was an open ground. Based on interview at the time of observation, the Administrator and the Maintenance Director acknowledged the outlet tested indicated an open ground. 3.1-19(b)		**POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. On 11-14-18 the Maintenance Supervisor/designee checked all rooms throughout the facility for surge protectors and multiplug adapters and checked all rooms with faucets to insure GFCI's were installed to meet set standards and found no other negative findings. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 11-16-18 the Administrator and Maintenance Supervisor/designee in serviced all staff on the requirement that surge protectors and multiplug adapters are prohibited from being used in the facility to meet set standards. 2.Maintenance Supervisor/designee will inspect rooms throughout the facility to insure surge protectors and multiplug adapters are not being used and inspect all areas with faucets to insure any electrical outlets nearby are GFCI outlets as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will	

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			monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11-24-18.**	