STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155154	A. BUILDING -- B. WING	04/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/27/21 Facility Number: 000074 Provider Number: 155154 AIM Number: 100290050 At this Emergency Preparedness survey, Spring Mill Meadows was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 130 certified beds. At the time of the survey, the census was 69. Quality Review completed on 05/04/21	E 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 5/19/2021.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/27/21 Facility Number: 000074 Provider Number: 155154 AIM Number: 100290050 At this Life Safety Code survey, Spring Mill Meadows was found not in compliance with	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 5/19/2021.	

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

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility with a basement was determined to be of Type II (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 130 and had a census of 69 at the time of this survey. All 74 resident sleeping rooms were surveyed. All areas where residents have customary access were sprinklered. The facility has one detached storage shed providing facility storage services which was not sprinklered. Quality Review completed on 05/04/21			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 1. Based on observation and interview, the facility failed to remove 1 of 3 essential electric system remote manual stop stations which was no longer in use. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by	K 0100	**K100 General Requirements - other** **What corrective action(s) will be accomplished for those residents found to have been**	05/19/2021

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	the Code, shall be either maintained or removed. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:30 p.m. to 4:20 p.m. on 04/27/20, three remote manual stop stations are located at the west nurse's station near the elevators on the first floor. Based on interview at the time of the observations, the Director of Maintenance stated the remote manual stop station located above the computer screen at the nurse's station was no longer operational and agreed the inoperable manual stop station should be removed to avoid confusion as to which stop stations were functional. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain latching hardware on 2 of 8 sets of 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 over 30 residents, staff, and visitors on the first floor. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:30 p.m. to 4:20 p.m. on 04/27/20, the smoke barrier door set on the first floor by the west nurse's station by the elevators was equipped with		**affected by the deficient practice?** · 1 - The inoperable manual stop station was removed. · 2 – The fire door by the first-floor west nurses' station was repaired to latch fully during self closure. · 2 – The smoke barrier door set by room 126 was repaired to latch fully during self closure. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · 1 - All residents on first floor west have the potential to be affected by the alleged deficient practice. ·2 – Residents on the first floor east, near room 126, have the potential to be affected by the alleged deficient practice. ·The Maintenance Supervisor will be inserviced by the Executive Director/designee on the regulatory standard indicated by this requirement by 5/19/2021. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·The Maintenance Supervisor will be inserviced by the Executive Director/designee on the regulatory standard indicated by this requirement by 5/19/2021.	

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	latching hardware on both doors. The south door latched into the door frame, but the face of the north door hit the face of the south door and failed to fully self close and latch into the door frame when tested to close multiple times. Each door in the door set was equipped with a one hour fire resistance rating label. In addition, the smoke barrier door set by Room 126 was also equipped with latching hardware, but the south door failed to latch the door into the door frame when tested to close multiple times. Each door in the door set was equipped with a one hour fire resistance rating label. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned smoke barrier door set's latching hardware failed to latch into the door frame when tested to close multiple times. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)		·As construction is completed on the building the Maintenance supervisor will ensure fire doors with self latching units are maintained to latch fully. **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?** · A life safety Review QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance **Date of Correction May 19, 2021**	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 2 of 12 means of egress was continuously maintained free of all obstructions	K 0211	**K211 Means of Egress General** **What corrective action(s) will be accomplished for those**	05/19/2021

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	or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 30 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:30 p.m. to 4:20 p.m. on 04/27/20, the following was noted: a. a love seat bench was stored up against the wall in the corridor outside the Medication Prep Room on the first floor, in the corridor outside Room 114 and in the corridor outside Room 118. Each bench projected 27 inches into the eight foot wide corridor as measured with a measuring tape. b. a plastic three drawer chest of drawers was placed up against the wall outside the first floor shower room and extended 16 inches into the eight foot wide corridor as measured with a measuring tape. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned means of egress was not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)		**residents found to have been affected by the deficient practice?** a. The love seat benches were removed from the corridors by the med room on the first floor west, the corridor outside room 114, and the corridor outside room 118. b. The plastic chest of drawers was removed outside the shower room. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents on the first floor and second floor west have the potential to be affected by the alleged deficient practice. · The Maintenance Supervisor will be inserviced by the Executive Director on the regulatory standard indicated by this requirement May 19, 2021. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The Maintenance Supervisor will be inserviced by the Executive Director/designee on keeping and 8-foot clearance in the corridors and the regulatory standard indicated by this requirement and also removed the furniture in both areas out of compliance by May	

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			19, 2021. · The Maintenance Supervisor/designee will make environmental rounds daily to ensure facility corridors remain clear of obstructions. **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?** · A life safety Review QA tool will be utilized daily x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance **Date of Correction May 19, 2021**	
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			

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

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	18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 2 of 5 exits on the first floor were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 10 residents, staff and visitors if needing to exit the facility\. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:30 p.m. to 4:20 p.m. on 04/27/20, the following was noted: a. the correct code was not posted for the stairwell door in the corridor by Room 112. The door was magnetically locked and could be released by entering a four digit code, but an incorrect code was posted which was entered and the door did not release to open. b. the exit door to the outside of the facility in the stairwell by Room 121 on the first floor was marked as a facility exit, was magnetically locked	K 0222	**K222 Egress Doors** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · A – The correct code for the stairwell next to room 112 was corrected and reposted. · B – The correct code for the exit door to the outside near the stairwell by room 121 was corrected and reposted. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents on the first floor have the potential to be affected by the alleged deficient practice. · The Maintenance Supervisor will be inserviced by the Executive Director on the regulatory standard indicated by this requirement by May 19, 2021. **What measures will be put into place or what systemic changes you will make to**	05/19/2021

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	and could be opened by entering a four digit code but the correct code was not posted to release the door to open. The posted code when entered did not release the door to open. Based on interview at the time of the observations, Director of Maintenance entered a different code than the posted code for the door by Room 112 which released the door to open. The Director of Maintenance attempted to release the stairwell door by Room 121 to open by entering different codes but none of the entered codes released the door to open. The Director of Maintenance stated the magnetic holding devices on the doors would release the doors to open if the fire alarm system was activated but agreed the correct code to release the doors to open was not posted. This finding was reviewed with the Executive Director during the exit conference 3.1-19(b)		**ensure that the deficient practice does not recur?** · The Maintenance Supervisor will be inserviced by the Executive Director on the regulatory standard indicated by this requirement by May 19, 2021. · The Maintenance Supervisor/designee will review all coded exits monthly to ensure codes provide egress correctly. **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?** · A life safety QA tool will be utilized monthly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance **Date of Correction May 19, 2021**	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be			

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	at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation and interview, the facility failed to meet the clear width requirement for 2 of 12 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8. This deficient practice could affect over 30 residents, staff and visitors.	K 0232	**K232 Aisle, corridor, or ramp width** **What corrective action(s) will be accomplished for those residents found to have been** · A - The love seat benches were removed from the corridors by the med room on the first floor west, the corridor outside room 114, and the corridor outside room 118. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents on the first floor and second floor west have the potential to be affected by the alleged deficient practice. · The Maintenance Supervisor will be inserviced by the Executive Director on the regulatory standard indicated by this requirement May 19, 2021. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The Maintenance Supervisor will be inserviced by the Executive Director/designee on keeping and 8-foot clearance in the corridors	05/19/2021

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	Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:30 p.m. to 4:20 p.m. on 04/27/20, a love seat bench was stored up against the wall in the corridor outside the Medication Prep Room on the first floor, in the corridor outside Room 114 and in the corridor outside Room 118. Each bench projected 27 inches into the eight foot wide corridor, as measured with a measuring tape, and each bench was not affixed to the floor or to the wall. Based on interview at the time of the observations, the Director of Maintenance agreed furniture was stored in the path of egress at the aforementioned locations and projected more than two feet into the eight foot wide corridor. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)		and the regulatory standard indicated by this requirement and also removed the furniture in both areas out of compliance by May 19, 2021. · The Maintenance Supervisor/designee will make environmental rounds daily to ensure facility corridors remain clear of obstructions. **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?** · A life safety Review QA tool will be utilized daily x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **Date of Correction May 19, 2021**	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected			

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	throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)			
	Based on observation and interview, the facility failed to ensure 5 of over 200 sprinkler heads in the facility were installed in accordance with NFPA 13. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition, Section 6.2.7.2 states escutcheons used with recessed, flush-type or concealed sprinklers shall be part of a listed sprinkler assembly. Section 6.2.7.3 states cover plates used with concealed sprinklers shall be part of the listed sprinkler assembly. This deficient practice could affect over 40 residents, staff and visitors on the first and second floor. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:30 p.m. to 4:20 p.m. on 04/27/20, the sprinkler location in the freezer in the kitchen was missing its escutcheon. The ceiling mounted sprinkler in the closet nearest the window in Room 118 was missing its escutcheon. The ceiling mounted	K 0351	**K351 Sprinkler Installation** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The escutcheons in room 118, 232, 236, and 237 were installed. · The residents in 118, 232, 236, and 237 could be affected by the alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All resident rooms were checked for escutcheons. ·The Maintenance Supervisor will be inserviced on the regulatory standard indicated by this	05/19/2021

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	recessed sprinklers located in Room 232, Room 236 and Room 237 were each missing its cover plate. Based on interview at the time of the observations, the Director of Maintenance stated the recessed sprinklers have never had a cover plate but agreed the sprinkler locations did not have an escutcheon or a cover plate. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)		requirement by May 19, 2021. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·The Maintenance Supervisor will be inserviced on the regulatory standard indicated by this requirement by May 19, 2021. ·Maintenance Supervisor/vendor support will make rounds to ensure escutcheons remain intact appropriately. **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?** · A life safety QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance **Date of Correction May 19, 2021**	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems			

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	are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	1. Based on record review and interview, the facility failed to ensure the sprinkler system was maintained in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.1 states the property owner or designated representative shall be responsible for properly maintaining a water based fire protection system. Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test, and maintenance required by this standard. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of the sprinkler system inspection contractor's "Form for Inspection, Testing and Maintenance of Wet Pipe Fire	K 0353	**K353 Sprinkler System – Testing and Maintenance** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · 1 - The alarm trim on the alarm valve was repaired and in operation. · 2a – The ceiling mounted sprinkler in the closet nearest the corridor in room 110 was replaced. · 2b – The deflector for the ceiling mounted sprinkler in the closet nearest the corridor in room 211 was replaced. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · 1 - All residents have the	05/19/2021

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	Sprinkler Systems" documentation dated 07/02/20 and 10/06/20 with the Executive Director and the Director of Maintenance during record review from 9:30 a.m. to 1:30 p.m. on 04/27/21, the alarm trim on the sprinkler system alarm valve is not in operation and needs to be removed. The "Deficiency Summary" section of aforementioned two reports stated "The alarm trim on the alarm valve is not in operation: it is closed off and needs to be removed. There is a vane-style flow switch that is active and working. This switch replaced the alarm valve, however if it is installed it must be in operation and it is not, therefore it needs to be removed". Based on interview at the time of record review, the Executive Director provided e-mail documentation on the status of repair from the sprinkler system contractor dated 04/27/21 at 12:19 p.m. stating "This has not been completed. I can get this scheduled for you". This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure over more than 2 of over 200 sprinkler heads in the facility which had been painted or loaded with foreign materials were replaced in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced:		potential to be affected by the alleged deficient practice. ·2 – Residents in room 110 and second floor in room 211, have the potential to be affected by the alleged deficient practice. ·The Maintenance Supervisor will be inserviced by the Executive Director/designee on the regulatory standard indicated by this requirement by 5/19/2021. ·All sprinklers were inspected and corrected as needed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·The Maintenance Supervisor will be inserviced by the Executive Director/designee on the regulatory standard indicated by this requirement by 5/19/2021. ·Maintenance Supervisor/vendor support will make rounds to ensure sprinklers remain in good repair. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A life safety Review QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance	

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	(1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect over 40 residents, staff, and visitors on the first and second floor. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:30 p.m. to 4:20 p.m. on 04/27/20, the following was noted: a. the ceiling mounted sprinkler in the closet nearest the corridor door in Room 110 was spray painted. b. the deflector for the ceiling mounted sprinkler in the closet nearest the corridor door in Room 211 was painted. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned sprinkler head locations were painted. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)		and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **Date of Correction May 19, 2021**	
K 0355 SS=E	NFPA 101 Portable Fire Extinguishers			

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Bldg. 01	Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 1. Based on observation and interview, the facility failed to ensure 4 of 17 portable fire extinguishers had the date of 6-year maintenance documented on each container in accordance with NFPA 10. NFPA 10, 2010 Edition, Section 7.3.1.1.2 states fire extinguishers shall be internally examined at intervals not exceeding those specified in Table 7.3.1.1.2. Section 7.3.1.2.1 states every six years, stored pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable internal examination procedure as detailed in the manufacturer's service manual and this standard. Sections 7.3.3.1 through 7.3.3.2 state fire extinguishers that pass the applicable 6-year requirement shall have the maintenance information recorded on a durable weatherproof label that is a minimum size of 2 inches by 3.5 inches. The label shall be affixed to the shell and shall include the month and year the maintenance was performed. The label shall include the initials of the person performing the maintenance and the name of the agency performing the maintenance. A verification of service collar shall be located around the neck of the container indicating the month and year of service and the name of the agency performing the maintenance or recharge. This deficient practice could affect 40 residents, staff, and visitors on the first and second floor. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:30	K 0355	**K355 Portable Fire Extinguishers** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · 1 - The four ABC type portable fire extinguishers located in the corridor by room 103, room 207, room 213, and room 235 received maintenance as prescribed every 6 years. · 2 – The ABC type portable fire extinguishers located by corridor room 207, room 213, and the basement mechanical room received maintenance as prescribed monthly. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · 1 - All residents on the second floor have the potential to be affected by the alleged deficient practice. ·2 – No residents would be affected by the alleged deficient practice in the basement mechanical room. ·All fire extinguishers were inspected, and corrections made	05/19/2021

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	p.m. to 4:20 p.m. on 04/27/20, the wall mounted ABC type portable fire extinguisher located in the corridor by Room 103, by Room 207, by Room 213 and by Room 235 each had a 6-year maintenance sticker and maintenance collar affixed to the container stating the most recent 6-year maintenance was performed in July 2014. Based on interview at the time of the observations, the Director of Maintenance agreed each of the four portable fire extinguishers did not have documented 6-year maintenance within the most recent six year period. This finding was reviewed with the Executive Director during the exit conference. 3-1.19(b) 2. Based on record review, observation, and interview; the facility failed to ensure 3 of 17 portable fire extinguishers had documented annual maintenance in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.3.1.1.1 states fire extinguishers shall be subject to maintenance at intervals of not more than one year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect over 20 residents, staff, and visitors. Findings include:		as needed. ·The Maintenance Supervisor will be inserviced by the Executive Director/designee on the regulatory standard indicated by this requirement by 5/19/2021. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·The Maintenance Supervisor will be inserviced by the Executive Director/designee on the regulatory standard indicated by this requirement by 5/19/2021. ·Maintenance Supervisor/vendor support will make rounds to ensure portable fire extinguishers receive maintenance per regulatory requirements. **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?** · A life safety Review QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	Based on review of the portable fire extinguisher inspection contractor's annual inspection documentation with the Executive Director and the Director of Maintenance during record review from 9:30 a.m. to 1:30 p.m. on 04/27/21, annual maintenance was performed for 17 portable fire extinguishers in the facility in January 2021. Based on observations with the Director of Maintenance during a tour of the facility from 1:30 p.m. to 4:20 p.m. on 04/27/20, the wall mounted ABC type portable fire extinguisher located in the corridor by Room 207, by Room 213 and in the basement Mechanical Room each had an affixed maintenance tag by the contractor, but the tag did not indicate the month and the year annual maintenance was performed. Based on interview at the time of the observations, the Director of Maintenance agreed the affixed maintenance tags did not indicate the month and the year annual maintenance was performed. This finding was reviewed with the Executive Director during the exit conference. 3-1.19(b)		**Date of Correction May 19, 2021**	
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			

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	combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 2 of 74 resident sleeping room corridor doors had no impediment to closing and latching into the door frame or would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors on the second floor. Findings include:	K 0363	**K363 Corridor - Doors** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · a - The Corridor door to room 230 obstruction was removed. · b – The one-inch gap for room 233 door frame was repaired.	05/19/2021

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	Based on observations with the Director of Maintenance during a tour of the facility from 1:30 p.m. to 4:20 p.m. on 04/27/20, the following was noted: a. the corridor door to Room 230 was propped in the fully open position with a trash can. b. a one inch gap was noted in between the top of the door and the door stop on the door frame for the corridor door to Room 233. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned corridor doors had an impediment to closing and latching into the door frame or would not resist the passage of smoke. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·a – The resident in room 230 could have been affected by the alleged deficient practice. ·b –The resident in room 233 could have been affected by the alleged deficient practice. ·The Maintenance Supervisor/all staff will be inserviced by the Executive Director/designee on the regulatory standard indicated by this requirement by 5/19/2021. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·The Maintenance Supervisor/all staff will be inserviced by the Executive Director/designee on the regulatory standard indicated by this requirement by 5/19/2021. ·Maintenance Supervisor/designee support will make rounds to ensure resident room doors close per regulatory requirements. **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?** · A life safety Review QA tool	

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			will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **Date of Correction May 19, 2021**	
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 openings through 1 of 3 ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes, and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material	K 0372	**K372 Subdivision of Building Spaces – Smoke Barriers** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The three holes in the basement ceiling in the laundry washer room were repaired.	05/19/2021

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	capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect over 30 residents, staff, and visitors on the first floor above the basement laundry rooms. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:30 p.m. to 4:20 p.m. on 04/27/20, three holes were noted in the basement ceiling smoke barrier in the washing machine room of the laundry in the basement. Based on interview at the time of the observations, Director of Maintenance agreed the aforementioned openings in the ceiling smoke barrier were not protected to maintain the fire resistance rating of the basement ceiling smoke barrier. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·No residents could have been affected by the alleged deficient practice. ·The Maintenance Supervisor/all staff will be inserviced by the Executive Director/designee on the regulatory standard indicated by this requirement by 5/19/2021. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·The Maintenance Supervisor will be inserviced by the Executive Director/designee on the regulatory standard indicated by this requirement by 5/19/2021. ·Maintenance Supervisor will make rounds to ensure there are no breaks in smoke barriers per regulatory requirements. **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?** · A life safety Review QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance	

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	155154	A. BUILDING 01 B. WING	04/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

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			and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **Date of Correction May 19, 2021**	
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 8 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 the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect over 30 residents, staff and visitors on the first floor. Findings include:	K 0374	**K374 Subdivision of Building Spaces – Smoke Barrier Doors** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The fire door by the first-floor west nurses' station was repaired to latch fully during self closure. **How will you identify other residents having the potential to be affected by the same**	05/19/2021

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	Based on observations with the Director of Maintenance during a tour of the facility from 1:30 p.m. to 4:20 p.m. on 04/27/20, the north door in the smoke barrier door set on the first floor by the west nurse's station by the elevators hit the face of the south door and failed to fully self close when tested to close multiple times. Each door in the door set was equipped with a one hour fire resistance rating label. Based on interview at the time of the observations, the Director of Maintenance agreed the north door in the aforementioned smoke barrier door set failed to fully self close when tested to close multiple times. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)		**deficient practice and what corrective action will be taken?** ·All residents on first floor west have the potential to be affected by the alleged deficient practice. ·The Maintenance Supervisor will be inserviced by the Executive Director/designee on the regulatory standard indicated by this requirement by 5/19/2021. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·The Maintenance Supervisor will be inserviced by the Executive Director/designee on the regulatory standard indicated by this requirement by 5/19/2021. ·As construction is completed on the building the Maintenance supervisor will ensure fire doors with self latching units are maintained to latch fully. **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?** · A life safety Review QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the	

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			Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **Date of Correction May 19, 2021**	
K 0541 SS=D Bldg. 01	NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chu Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 Based on observation and interview, the facility failed to ensure 1 of 1 laundry chutes was maintained in accordance with NFPA 82. NFPA	K 0541	**K541 Rubbish Chutes, Incinerators, and Laundry Chutes**	05/19/2021

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	82, Standard on Incinerators and Waste and Linen Handling Systems and Equipment, 2009 Edition, Section 5.2.3.2.2 states the bottom of a linen chute shall be protected by a listed automatic closing or self closing door in accordance with Section 5.2.3.1. Section 5.2.3.1.3 states openings shall be as follows: (1) 1 1/2 fire resistance rating for 2-hour rated enclosures. (2) 1-hour fire resistance rating for 1-hour rated enclosures. This deficient practice could affect over two staff in the basement in the vicinity of the washing machine room. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:30 p.m. to 4:20 p.m. on 04/27/20, the bottom of the linen chute in the washing machine room in the basement was not enclosed with an automatic closing or self closing door. Based on interview at the time of the observations, the Director of Maintenance agreed the bottom of the linen chute was not enclosed with an automatic closing or self closing door. This finding was reviewed with the Executive Director during the exit conference 3.1-19(b)		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The linen chute in the washing machine room in the basement was repaired to include a self-closing door. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·No residents have the potential to be affected by the alleged deficient practice. ·The Maintenance Supervisor will be inserviced by the Executive Director/designee on the regulatory standard indicated by this requirement by 5/19/2021. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·The Maintenance Supervisor will be inserviced by the Executive Director/designee on the regulatory standard indicated by this requirement by 5/19/2021. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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			· A life safety Review QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **Date of Correction May 19, 2021**	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.			

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	10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, 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. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed, and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over 30 residents, staff, and visitors in the vicinity of Room 219. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:30 p.m. to 4:20 p.m. on 04/27/20, an IV pump, a fan, a	K 0920	**K920 Electrical Equipment – power cords and extension cords** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The power strip was removed from resident room 219. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·The resident in room 219 could have been affected by the alleged deficient practice. ·All resident rooms were checked for power cords and extension cords. ·The Maintenance Supervisor/all staff will be inserviced by the Executive Director/designee on the regulatory standard indicated by this requirement by 5/19/2021. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·The Maintenance Supervisor/all staff will be inserviced by the Executive Director/designee on the regulatory standard indicated by this requirement by 5/19/2021. ·The maintenance Supervisor	05/19/2021

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	stereo, and a television were plugged into a power strip on the floor within one foot of the resident bed nearest the corridor door in resident sleeping Room 219. The UL listing of the power strip was identified with a sticker on the power strip as E157293. Based on interview at the time of the observations, the Director of Maintenance agreed a power strip was being used for PCREE and non-PCREE within the patient care vicinity and as a substitute for fixed wiring. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)		will make daily rounds to ensure power cords/extension cords are not being used. **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?** · A life safety Review QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **Date of Correction May 19, 2021**	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated			

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	from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 1 oxygen storage and transfilling rooms. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.1 states storage for nonflammable gases equal to or greater than 85 cubic meters (3000 cubic feet) shall comply with 5.1.3.3.2 and 5.1.3.3.3. NFPA 99, Section 5.1.3.3.2(7) requires cylinders be provided with racks, chains, or other fastenings to secure all cylinders from falling, whether connected,	K 0923	**K923 Gas Equipment – Cylinder and Container Storage** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The E Type oxygen cylinders were placed in the correct storage stand to secure them from falling. **How will you identify other residents having the potential**	05/19/2021

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	unconnected, full or empty. This deficient practice could affect over 30 residents, staff and visitors in the vicinity of the second floor oxygen storage and transfilling room near Room 203. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:30 p.m. to 4:20 p.m. on 04/27/20, one of five 'E' type oxygen cylinders were freestanding on the floor inside the second floor oxygen storage and transfilling room near Room 203 and were not supported in a proper cylinder stand or otherwise secured from falling. The oxygen storage and transfilling room had three liquid oxygen containers and five 'E' type oxygen cylinders stored in the room. Based on interview at the time of the observations, the Director of Maintenance moved the unsupported cylinder to a supporting rack in the room but agreed the one oxygen cylinder had not been supported in a cylinder stand or otherwise secured from falling. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)		**to be affected by the same deficient practice and what corrective action will be taken?** ·The resident in room 203 could have been affected by the alleged deficient practice. ·The Maintenance Supervisor/all staff will be inserviced by the Executive Director/designee on the regulatory standard indicated by this requirement by 5/19/2021. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·The Maintenance Supervisor/all staff will be inserviced by the Executive Director/designee on the regulatory standard indicated by this requirement by 5/19/2021. ·The maintenance Supervisor/designee will make daily rounds to ensure the freestanding cylinders are in the appropriate storage stand. **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?** · A life safety Review QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement	

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			Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **Date of Correction May 19, 2021**	