| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155157 | A. BUILDING -- B. WING | 06/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| BRICKYARD HEALTHCARE - RICHMOND CARE CENTER | 1042 OAK DR RICHMOND, IN 47374 |

| (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 |
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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 06/06/23<br><br>Facility Number: 000077<br>Provider Number: 155157<br>AIM Number: 100266490<br><br>At this Emergency Preparedness survey, Brickyard Healthcare - Richmond Care Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.<br><br>The facility has 122 certified beds. At the time of the survey, the census was 52.<br><br>Quality Review completed on 06/09/23 | E 0000 | Preparation, submission and implementation of this Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction was prepared and executed as a means to continuously improve the quality of care and comply with all applicable federal and state requirements.<br><br>The facility respectfully requests a desk review of our responses to this survey. | |
| E 0006<br>SS=C<br>Bldg. -- | 403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2)<br>Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Joanne L Denney | Executive Director | 06/23/2023 |

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | 155157 | A. BUILDING -- B. WING | 06/06/2023 |

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| | §491.12(a)(1)-(2), §494.62(a)(1)-(2)<br><br>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:]<br><br>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*<br><br>(2) Include strategies for addressing emergency events identified by the risk assessment.<br><br>* [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:<br>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.<br>(2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.<br><br>*[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: | | | |

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| | (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.<br>(2) Include strategies for addressing emergency events identified by the risk assessment.<br><br>*[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:<br><br>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.<br>(2) Include strategies for addressing emergency events identified by the risk assessment.<br>Based on record review and interview, the facility failed to maintain an emergency preparedness plan (EPP) that was based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients and included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.475(a) (1) and 42 CFR 483.475(a) (2). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on review of the facility's Emergency Preparedness Plan and interview with the Maintenance Supervisor and Maintenance Assistant on 06/06/23 between 10:25 a.m. and 12:15 p.m., no documentation was available to show that the Emergency Disaster Preparedness | E 0006 | What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿<br>Updates were completed 6/6/23<br><br>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿<br><br>Initial audit: EPP was completed | 06/06/2023 |

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| | Plan was based on and included a documented facility-based and community-based risk assessment, utilizing an all-hazards approach. The Maintenance Supervisor, who is new to the facility stated that he looked through the EPP recently, but simply overlooked the All-Hazards Risk Assessment. Based on interview at the time of records review, the Maintenance Supervisor paperwork of a risk assessment could not be found.<br><br>This finding was acknowledged by the Maintenance Supervisor and Maintenance Assistant at the time of discovery and again at the exit conference with the Maintenance Supervisor and Maintenance Assistant present. | | What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿<br><br>Ensure location/tab is accurate for review<br><br>·¿<br><br>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place¿<br><br>QAPI will review quarterly for one year. | |
| E 0029 SS=C Bldg. -- | 403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c)<br>Development of Communication Plan<br>§403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c).<br><br>(c) The [facility] must develop and maintain | | | |

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| | 155157 | A. BUILDING -- B. WING | 06/06/2023 |

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| | an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities].<br>Based on record review and interview, the facility failed to develop and maintain a complete emergency preparedness communication plan that complies with Federal, State, and local laws in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on review of the facility's Emergency Preparedness Plan and interview with the Maintenance Supervisor and Maintenance Assistant on 06/06/23 between 10:25 a.m. and 12:15 p.m., the provided EPP did not include current contact information for the facilities Administrator. According to records, the EPP plan was updated on 06/01/23 however the name and contact information for the Administrator was for a previous Administrator.<br><br>This finding was acknowledged by the Maintenance Supervisor and Maintenance Assistant at the time of discovery and again at the exit conference with the Maintenance Supervisor and Maintenance Assistant present. | E 0029 | What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Hazard risk assessment was completed 6/6/23 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ Initial audit: Hazard risk assessment was completed What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿ Ensure location/tab is accurate for review .¿ How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place¿ QAPI will review quarterly for one year. | 06/06/2023 |
| E 0041 SS=F Bldg. -- | 482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) | | | |

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| | (i) and (ii) of this section.<br><br>§483.73(e), §485.625(e)<br>(e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.<br><br>§482.15(e)(1), §483.73(e)(1), §485.625(e)(1)<br>Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.<br><br>482.15(e)(2), §483.73(e)(2), §485.625(e)(2)<br>Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.<br><br>482.15(e)(3), §483.73(e)(3), §485.625(e)(3)<br>Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.<br><br>*[For hospitals at §482.15(h), LTC at | | | |

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| | §483.73(g), and CAHs §485.625(g):]<br>The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.<br>If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.<br>(1) National Fire Protection Association, 1 Batterymarch Park,<br>Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.<br>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.<br>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.<br>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.<br>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.<br>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.<br>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.<br>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.<br>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011. | | | |

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| | (ix) TIA 12-2 to NFPA 101, issued October 30, 2012.<br>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.<br>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.<br>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..<br>Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on records review and interview with the Maintenance Supervisor and Maintenance Assistant on 06/06/23 between 10:25 a.m. and 12:15 p.m., no documentation of an annual fuel quality test within the last 12 months for the diesel generator was available for review. The most recent test was dated 04/07/22 and was over a year old. Based on interview at the time of records review, a more recent fuel quality test report for the diesel fired generator could not be located.<br><br>This finding was acknowledged by the Maintenance Supervisor and Maintenance Assistant at the time of discovery and again at the exit conference with the Maintenance Supervisor and Maintenance Assistant present. | E 0041 | What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿<br>Fuel test completed 6/19/23 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ Initial audit: Fuel test was scheduled. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿ New Vendor will annually complete test .¿ How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place¿ QAPI will review quarterly for one year. | 06/19/2023 |
| K 0000<br><br>Bldg. 01 | | | | |

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| | 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).<br><br>Survey Date: 06/06/23<br><br>Facility Number: 000077<br>Provider Number: 155157<br>AIM Number: 100266490<br><br>At this Life Safety Code survey, Brickyard Healthcare - Richmond Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 122 and had a census of 52 at the time of this visit.<br><br>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has two detached wooden storage sheds which were not sprinkled.<br><br>Quality Review completed on 06/09/23 | K 0000 | Preparation, submission and implementation of this Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction was prepared and executed as a means to continuously improve the quality of care and comply with all applicable federal and state requirements.<br><br>The facility respectfully requests a desk review of our responses to this survey. | |
| K 0222<br>SS=E<br>Bldg. 01 | NFPA 101<br>Egress Doors<br>Egress Doors | | | |

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| | 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:<br>CLINICAL NEEDS OR SECURITY THREAT LOCKING<br>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.<br>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6<br>SPECIAL NEEDS LOCKING ARRANGEMENTS<br>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.<br>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4<br>DELAYED-EGRESS LOCKING ARRANGEMENTS<br>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door | | | |

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| | 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.<br>18.2.2.2.4, 19.2.2.2.4<br>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS<br>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.<br>18.2.2.2.4, 19.2.2.2.4<br>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS<br>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.<br>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 2 short hall exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect 20, residents, staff and visitors if needing to exit the facility.<br><br>Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance | K 0222 | What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿<br>Codes were reattached How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ Initial audit: all doors have code as of 6/20/23 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿ Added to PM review monthly How the corrective action will be monitored to ensure | 06/20/2023 |

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| | 155157 | A. BUILDING 01<br>B. WING | 06/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| BRICKYARD HEALTHCARE - RICHMOND CARE CENTER | 1042 OAK DR<br>RICHMOND, IN 47374 |

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| | Supervisor and Maintenance Assistant on 06/06/23 between 12:15 p.m. and 2:15 p.m., the exit door from the (1) ECU Short Hall and the (2) TCU Short Hall, marked as facility exits, were magnetically locked and could be opened by entering a four digit code but the code was not posted at the exits. The Maintenance Assistant stated he had recently changed all the door codes but had apparently missed the aforementioned two exits.<br><br>This finding was acknowledged by the Maintenance Supervisor and Maintenance Assistant at the time of discovery and again at the exit conference with the Maintenance Supervisor and Maintenance Assistant present.<br><br>3.1-19(b) | | the deficient practice will not recur, i.e., what quality assurance program will be put into place¿ QAPI will review quarterly for one year. | |
| K 0361 SS=E Bldg. 01 | NFPA 101<br>Corridors - Areas Open to Corridor<br>Corridors - Areas Open to Corridor<br>Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1.<br>18.3.6.1, 19.3.6.1<br>Based on observation and interview, the facility failed to ensure the occupational therapy office with a pass-through window greater than 20 square inches met the requirements of spaces open to the corridor. LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised | K 0361 | What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿<br>Smoke detector was added on the ceiling hard wired into existing system by Safe Care How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ All | 06/19/2023 |

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| | automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. LCS 19.3.6.5.1 states miscellaneous openings, such as mail slots, pharmacy pass-through windows, laboratory pass-through windows, and cashier pass-through windows, shall be permitted to be installed in vision panels or doors without special protection, provided that both of the following criteria are met:<br>(1) The aggregate area of openings per room does not exceed 20 inches squared (0.015 m2).<br>(2) The openings are installed at or below half the distance from the floor to the room ceiling.<br>This deficient practice could affect staff and up to 6 residents.<br><br>Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Maintenance Assistant on 06/06/23 between 12:15 p.m. and 2:15 p.m., the Occupational Therapy Office area had pass-through window and the therapy area was not protected by electrically supervised automatic smoke detection. Based on interview at the time of observation, the Maintenance Supervisor agreed the windows were greater than 20 square inches and did not contain electrically supervised automatic smoke detection.<br><br>This finding was acknowledged by the Maintenance Supervisor and Maintenance Assistant at the time of discovery and again at the exit conference with the Maintenance Supervisor and Maintenance Assistant present.<br><br>3.1-19(b) | | other doors were in compliance What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿ Hard wired to smoke detectors which are inspected monthly.How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place¿ QAPI will review quarterly for one year. | |

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| K 0363 SS=E Bldg. 01 | NFPA 101<br>Corridor - Doors<br>Corridor - Doors<br>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.<br><br>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.<br>Based on observation and interview, the facility failed to ensure all corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 2 staff and 2 residents.<br><br>Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Maintenance Assistant on 06/06/23 between 12:15 p.m. and 2:15 p.m., the following corridor doors failed to latch positively into their respective door frames:<br>a) Resident Room #17<br>b) Clean Storage room door on the TCU hall, equipped with a self-closing device, failed to self-close and latch.<br><br>This finding was acknowledged by the Maintenance Supervisor and Maintenance Assistant at the time of discovery and again at the exit conference with the Maintenance Supervisor and Maintenance Assistant present.<br><br>3.1-19(b) | K 0363 | What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿<br>Resident door #17 and clean storge by TCU was repaired 6/19/23 by replacing hardware How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ PM added semiannually random check of doors latching. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿ Work orders for doors will be completed How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place¿ QAPI will review quarterly for one year. | 06/19/2023 |
| K 0374 SS=E Bldg. 01 | NFPA 101<br>Subdivision of Building Spaces - Smoke Barrie<br>Subdivision of Building Spaces - Smoke Barrier Doors<br>2012 EXISTING<br>Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. | | | |

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| | 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.<br>19.3.7.6, 19.3.7.8, 19.3.7.9<br>Based on observation and interview, the facility failed to ensure 2 of 5 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 23 residents.<br><br>Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Maintenance Assistant on 06/06/23 between 12:15 p.m. and 2:15 p.m., the double sets of fire/smoke doors at (1) near Resident Room 18 and (2) near Occupational Therapy did not close completely and latch. Based on interview during the time of observations, the Maintenance Supervisor and Maintenance Assistant acknowledged these fire/smoke barrier doors did not close completely and latch stating that they recently checked all the doors and were surprised that the doors were not functioning correctly.<br><br>This finding was acknowledged by the Maintenance Supervisor and Maintenance Assistant at the time of discovery and again at the exit conference with the Maintenance Supervisor | K 0374 | What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿<br>Double doors by resident room #18 near OT are being repaired by Safe CARE 6/22/23<br><br>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿<br><br>All other doors were in compliance<br><br>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿<br><br>PM random checks to ensure doors latching<br><br>How the corrective action will be monitored to ensure the deficient | 06/22/2023 |

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| | and Maintenance Assistant present.<br><br>3.1-19(b) | | practice will not recur, i.e., what quality assurance program will be put into place¿<br><br>QAPI will review quarterly for one year. | |
| K 0741<br>SS=F<br>Bldg. 01 | NFPA 101<br>Smoking Regulations<br>Smoking Regulations<br>Smoking regulations shall be adopted and shall include not less than the following provisions:<br>(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.<br>(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.<br>(3) Smoking by patients classified as not responsible shall be prohibited.<br>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.<br>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.<br>(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. | | | |

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| | 18.7.4, 19.7.4<br>Based on observation and interview; the facility failed to ensure 2 of 2 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect staff and all residents, staff and visitors.<br><br>Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Maintenance Assistant on 06/06/23 between 12:15 p.m. and 2:15 p.m. and observations at the beginning of the survey at approximately 9:45 a.m., the facility had over 150 cigarette butts disposed on the ground in and around the facility including near the main entrance and space between the parking lot and main campus. The Maintenance Supervisor stated that smoking is allowed for both staff and residents in the two designated smoking areas and that residents are supervised whenever they smoke. The Maintenance Supervisor and Maintenance Assistant stated that the butts scattered around the campus are likely the result of staff. During the survey, an employee identified by the Maintenance Assistant as a CNA was picking up cigarette butts around the facility with a large trash bag and it was noted by the surveyor and the Maintenance Assistant that the aforementioned employee was smoking as she walked around the campus collecting the butts disposed of on the ground.<br><br>This finding was acknowledged by the Maintenance Supervisor and Maintenance Assistant at the time of discovery and again at the exit conference with the Maintenance Supervisor and Maintenance Assistant present. | K 0741 | What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿<br>Cigarette butts were cleaned up in affected areas<br><br>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿<br><br>All areas were cleaned up outside.<br><br>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿<br><br>All staff were in-serviced on smoking locations for Residents and staff 6/19/23<br><br>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place¿<br><br>QAPI will review quarterly for one year. | 06/19/2023 |

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| | 3.1-19(b) | | | |
| K 0918<br>SS=F<br>Bldg. 01 | NFPA 101<br>Electrical Systems - Essential Electric Syste<br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, | | | |

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| | NFPA 111, 700.10 (NFPA 70)<br>Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 facility's diesel-powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents.<br><br>Findings include:<br><br>Based on records review and interview with the Maintenance Supervisor and Maintenance Assistant on 06/06/23 between 10:25 a.m. and 12:15 p.m., no documentation of an annual fuel quality test within the last 12 months for the diesel generator was available for review. The most recent test was dated 4/7/22 and was over a year old. Based on interview at the time of records review, a more recent fuel quality test report for the diesel fired generator could not be located.<br><br>This finding was acknowledged by the Maintenance Supervisor and Maintenance Assistant at the time of discovery and again at the exit conference with the Maintenance Supervisor and Maintenance Assistant present.<br><br>3.1-19(b) | K 0918 | What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿<br>Fuel test completed 6/19/23<br><br>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿<br><br>Initial audit: Fuel test was scheduled.<br><br>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿<br><br>New Vendor will annually complete test<br><br>.¿<br><br>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be | 06/19/2023 |

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| | | | put into place¿<br><br>QAPI will review quarterly for one year. | |