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	05/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-RICHMOND	1042 OAK DR RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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: 05/25/21 Facility Number: 000077 Provider Number: 155157 AIM Number: 100266490 At this Emergency Preparedness survey, Golden Living Center-Richmond was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 122 certified beds. At the time of the survey, the census was 56. Quality Review completed on 05/27/21	E 0000	The creation and submission of this Plan of Correction (POC) 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 this *CMS-2567 Plan of Correction* be considered the *Letter of Credible Allegation of Compliance* and requests a desk review in lieu of a post-survey review on, or after June 24, 2021.	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at			

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

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	§483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training.			

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	(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training.			

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	(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies			

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	and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the	E 0037	It is the practice of this provider to	06/24/2021

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	facility failed to ensure the emergency preparedness training and testing program includes a training program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d)(1). This deficient practice could affect all residents in the facility. Findings include: Based on review of the Emergency Preparedness Disaster Manual with the Maintenance Supervisor (MS) on 05/25/21 at 10:40 a.m., there was no documentation to indicate facility staff were trained on the Emergency Preparedness Disaster Manual over the past year. Based on an interview with the Administrator, it was stated the facility has not trained the staff and documented the training on the Emergency Preparedness Disaster Manual and the facility does not have a testing program. This was confirmed and reviewed with the Administrator during the exit conference.		ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* Training on the Emergency Preparedness Disaster Manual (EPDM) is conducted for all new employees and no less frequently than annually thereafter. Evidence of the annual training and subsequent testing will be retained per compliance. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?* All residents in the facility have the potential to be affected by the same alleged deficient practice. Training on the Emergency Preparedness Disaster Manual (EPDM) is conducted for all new employees and no less frequently than annually thereafter. Evidence of the annual training and subsequent testing will be retained per compliance. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*	

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K 0000			Facility staff responsible for the EPDM training and subsequent testing will be inserviced on the alleged deficient practice and will be educated in accordance with facility policy and professional standards of practice. *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?* Progress toward the successful completion of this Plan of Correction (POC) will be monitored using the *GLCR (0096) E037-20210525 Audit Tool*. Progress will be monitored on business days for one (1) month, weekly for four (4) weeks, and semi-monthly for four (4) months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Executive Director (Administrator) and/or designee will review the audit tool(s) on business days during StandUp, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Executive Director (Administrator) and/or designee will be responsible for monitoring this POC to ensure its successful completion.	

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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: 05/25/21 Facility Number: 000077 Provider Number: 155157 AIM Number: 100266490 At this Life Safety Code survey, Golden Living Center-Richmond was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully 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 56 at the time of this visit. 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. Quality Review completed on 05/27/21	K 0000	The creation and submission of this Plan of Correction (POC) 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 this *CMS-2567 Plan of Correction* be considered the *Letter of Credible Allegation of Compliance* and requests a desk review in lieu of a post-survey review on, or after June 24, 2021.	

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K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation and interview the facility failed to maintain exit access routes free and clear of obstructions for 1 of 5 corridor exit access in accordance with the requirements of NFPA 101, 2012 edition, sections 19.2, 19.2.1, 7.1.10 and 7.1.10.1. This deficient practice could affect any resident, staff or visitor exiting through the Vacant hall. Findings include: Based on observation on 05/25/21 at 12:35 p.m. with the Maintenance Supervisor (MS) there was two resident beds stored in the corridor of the Vacant hall reducing the eight foot width of the corridor to 52 inches. Based on interview concurrent with the observation with the MS it was stated the beds were just there temporarily and would be removed. This was discussed with Administrator and MS during the exit conference. 3.1-19(b)	K 0232	It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* The vacant corridor was cleared immediately after LSC survey exit conference. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?* All residents in the facility have the potential to be affected by the same alleged deficient practice. The vacant corridor was cleared immediately after LSC survey exit conference. All aisles or corridors in facility will be monitored to ensure regulatory compliance regarding areas serving as exit access.	06/24/2021

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			What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? All staff will be inserviced on the alleged deficient practice and will be educated in accordance with facility policy and professional standards of care (see attached policies and/or related documents). *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?* Progress toward the successful completion of this Plan of Correction (POC) will be monitored using the *GLCR (0096) K232-20210525 Audit Tool*. Progress will be monitored on business days for one (1) month, weekly for four (4) weeks, and semi-monthly for four (4) months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Executive Director (Administrator) and/or designee will review the audit tool(s) on business days during StandUp, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Executive Director (Administrator) and/or designee will be	

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			responsible for monitoring this POC to ensure its successful completion.	
K 0321 SS=D Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility	K 0321	It is the practice of this provider to	06/24/2021

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	failed to ensure 2 of 5 hazardous areas observed such as Storage rooms over 50 square feet, would latch in their frame and be provided with a self-closing device. This deficient practice could affect residents in the adjacent smoke compartment as well as staff on the vacant hall. Findings include: Based on observations on 05/25/21 at 12:32 p.m. with the Maintenance Supervisor (MS), there were over 50 cardboard boxes stored in the PPE storage room on the Vacant hall and there was no self closing device on the corridor door. Furthermore, there were 40 cardboard boxes and a biohazard container in the storage room next to room # 12 and the corridor door was not equipped with a self closing device. Based on interview at the time of observations with the MS it was stated he did not even think about the two storage areas as hazardous rooms and acknowledged they should have been provided with self closing devices. It was further acknowledged the area was over 50 square feet. This was discussed with the Administrator and MS during the exit conference. 3.1-19(b)		ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* Self-closing devices were installed on the two storage room doors in question, ensuring they would latch in their frames. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?* All residents in the facility have the potential to be affected by the same alleged deficient practice. Self-closing devices were installed on the two storage room doors in question, ensuring they would latch in their frames. All storage areas in facility in excess of fifty (50) square feet will be monitored to ensure regulatory compliance. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?* Related staff will be inserviced on the alleged deficient practice and will be educated in accordance with facility policy and professional standards. All storage	

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			areas in facility in excess of fifty (50) square feet will be monitored to ensure regulatory compliance. *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?* Progress toward the successful completion of this Plan of Correction (POC) will be monitored using the *GLCR (0096) K321-20210525 Audit Tool*. Progress will be monitored on business days for one (1) month, weekly for four (4) weeks, and semi-monthly for four (4) months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Executive Director (Administrator) and/or designee will review the audit tool(s) on business days during StandUp, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Executive Director (Administrator) and/or designee will be responsible for monitoring this POC to ensure its successful completion.	
K 0351 SS=F 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 a 1 of 1 complete automatic sprinkler system was installed in accordance with 19.3.5.1. NFPA 13, 2010 Edition, Standard for the Installation of Sprinkler Systems, Section 9.1.1.7, Support of Non-System Components, requires sprinkler piping or hangers shall not be used to support non-system components. This deficient practice could affect 12 residents, staff and visitors. Findings include: Based on observation on 05/25/21 at 12:37 p.m. with the Maintenance Supervisor (MS), above the ceiling next to the Conference room there were several low voltage wires wrapped around a metal sprinkler pipe. Based on interview at the time of observation, the MS acknowledged, non-sprinkler components were attached to the steel sprinkler pipe and was unaware of this condition. This was discussed with the	K 0351	It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* Low-voltage wires were removed and re-routed from the sprinkler system piping/hangers shortly after the LSC survey exit conference. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?* All residents in the facility have	06/24/2021

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	155157	A. BUILDING 01 B. WING	05/25/2021

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	Administrator and MS during the exit conference. 3.1-19(b)		the potential to be affected by the same alleged deficient practice. Low-voltage wires were removed and re-routed from the sprinkler system piping/hangers shortly after the LSC survey exit conference. Full-facility sweep checking all sprinkler system piping/hangers will be conducted to ensure regulatory compliance. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?* Related staff will be inserviced on the alleged deficient practice and will be educated in accordance with facility policy and professional standards. Full-facility sweep checking all sprinkler system piping/hangers will be conducted to ensure regulatory compliance. *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?* Progress toward the successful completion of the full-facility sweep relative to this Plan of Correction (POC) will be monitored using the *GLCR (0096) K351-20210525 Audit Tool*. Progress will be monitored on business days for one (1) month, weekly for four (4) weeks, and semi-monthly for four (4) months	

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			or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Executive Director (Administrator) and/or designee will review the audit tool(s) on business days during StandUp, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Executive Director (Administrator) and/or designee will be responsible for monitoring this POC to ensure its successful completion.	
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 1 of 6 smoke barriers observed had a minimum of a 1/2 hour fire resistive rating and the penetrations caused by the passage of wire and/or conduit the smoke barrier walls was protected to maintain the smoke resistance of	K 0372	It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state	06/24/2021

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	each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect 12 residents, visitors and staff. Findings include: Based on observation on 05/25/21 at 1:04 p.m. with the Maintenance Supervisor (MS), above the ceiling tiles of the smokewall next to resident room # 30, there was a five inch diameter sprinkler pipe penetrating the smokewall and the one inch gap around the pipe was not sealed. Based on interview after physical observation by the MS it was stated the contractors had recently installed the sprinkler pipe and neglected to seal around it. This finding was reviewed with the Administrator and MS at the exit conference. 3.1-19(b)		law. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* The affected smoke barrier wall penetration with a one-inch gap around the sprinkler pipe was sealed to ensure compliance. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?* All residents in the facility have the potential to be affected by the same alleged deficient practice. The affected smoke barrier wall penetration with a one-inch gap around the sprinkler pipe was sealed to ensure compliance. All smoke barrier walls were verified to ensure regulatory compliance (six (6) total). *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?* Related staff will be inserviced on the alleged deficient practice and will be educated in accordance with facility policy and professional standards. All smoke barrier walls were verified to ensure regulatory compliance (six (6) total). *How the corrective action(s) will be monitored to ensure the*	

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			deficient practice will not recur, i.e., what quality assurance program will be put into place? Progress toward the successful completion of the full-facility sweep relative to this Plan of Correction (POC) will be documented using the *GLCR (0096) K372-20210525 Audit Tool*. Completion will be documented. The Executive Director (Administrator) and/or designee will be responsible for monitoring this POC to ensure its successful completion.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 electrical receptacles observed was protected accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect all 10 residents, visitors and staff. Findings include: Based on observation on 05/25/21 at 12:49 p.m.	K 0511	It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* The affected junction box located in the attic with the wires exposed (no plate cover) was covered to	06/24/2021

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	with the Maintenance Supervisor (MS), one electrical junction box with wires exposed was missing a plate cover above the ceiling tiles next to the Conference room. Based on interview at the time of observation, the MS confirmed the receptacle cover plate was missing and said he would take care of this right away. This was discussed with the Administrator and the MS during the exit conference. 3.1-19(b)		ensure compliance. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?* All residents in the facility have the potential to be affected by the same alleged deficient practice. The affected junction box located in the attic with the wires exposed (no plate cover) was covered to ensure compliance. All junction boxes in the attic were verified to ensure regulatory compliance. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?* Related staff will be inserviced on the alleged deficient practice and will be educated in accordance with facility policy and professional standards. All junction boxes in the attic were verified to ensure regulatory compliance. *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?* Progress toward the successful completion of the full-facility sweep relative to this Plan of Correction (POC) will be documented using the *GLCR (0096) K511-20210525 Audit*	

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			Tool. Completion will be documented. The Executive Director (Administrator) and/or designee will be responsible for monitoring this POC to ensure its successful completion.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (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. (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. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (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. 18.7.4, 19.7.4 Based on record review, observation and	K 0741	It is the practice of this provider to	06/24/2021

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	interview, the facility failed to ensure a non-combustible container into which cigarette butts can be disposed of was not combined with disposal of paper goods in 1 of 2 outdoor areas where evidence of smoking occurred. This deficient practice could affect any number of residents and staff who use the outside smoking locations. Findings include: Based on review of the facility's written smoking policy on 05/25/21 at 10:42 a.m. with the Maintenance Supervisor (MS), resident and staff smoking is permitted on the premises at the designated locations. Based on observation with the MS on 05/25/21 at 1:20 p.m., the smoking area for residents; ECU courtyard, was provided with the appropriate metal can with a self closing lid where cigarette butts were properly disposed of, however, paper goods were also observed among the trash. Based on interview concurrent with the observation the MS was discouraged to see that paper goods were thrown in the metal can with the cigarette butts. This was discussed with the Administrator and MS during the exit conference. 3.1-19(b)		ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* Non-combustible disposal container for cigarette butts was labeled and an additional container for the disposal of all other paper goods was provided and labeled as such. All staff inserviced on this protocol as it relates to the disposal of cigarette butts and other paper goods. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?* All residents in the facility have the potential to be affected by the same alleged deficient practice. Non-combustible disposal container for cigarette butts was labeled and an additional container for the disposal of all other paper goods was provided and labeled as such. Staff inserviced on this protocol as it relates to the disposal of cigarette butts and other paper goods. Smoking areas will be monitored to ensure compliance. *What measures will be put into place and what systemic*	

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			changes will be made to ensure that the deficient practice does not recur? Staff will be inserviced on the alleged deficient practice and will be educated in accordance with facility policy and professional standards. Smoke area(s) will be monitored to ensure regulatory compliance. *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?* Progress toward the successful completion of this Plan of Correction (POC) will be monitored using the *GLCR (0096) K741-20210525 Audit Tool*. Progress will be monitored on business days for one (1) month, weekly for four (4) weeks, and semi-monthly for four (4) months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Executive Director (Administrator) and/or designee will review the audit tool(s) on business days during StandUp, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Executive Director (Administrator) and/or designee will be responsible for monitoring this POC to ensure its successful completion.	

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K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen transfilling rooms was mechanically ventilated. NFPA 99 2012 edition, 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated. This deficient practice could affect 12 residents, visitors or staff. Findings include: Based on observation on 05/25/21 at 11:55 a.m. with the Maintenance Supervisor (MS), the Oxygen storage room on ECU hall, where oxygen transfilling occurred had a ceiling exhaust fan which appeared not to work. Based on an interview at the time of observation, the MS was asked to test the exhaust vent with a piece of paper to observe air movement which would indicate the ceiling vent was working. Moments later without doing the paper test it was acknowledged by the MS, he had just checked the vent recently and it was working, but now he could tell it was not working and would need to	K 0927	It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* Non-functioning exhaust fan in the oxygen storage room was replaced shortly after LSC survey exit conference. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?* All residents in the facility have the potential to be affected by the same alleged deficient practice.	06/24/2021

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	be replaced. This finding was reviewed with the Administrator MS at the exit conference. 3.1-19(b)		Non-functioning exhaust fan in the oxygen storage room was replaced shortly after LSC survey exit conference. Oxygen storage room will be monitored to ensure compliance. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?* Oxygen storage room will be monitored to ensure regulatory compliance. *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?* Progress toward the successful completion of this Plan of Correction (POC) will be documented using the *GLCR (0096) K927-20210525 Audit Tool*. Replacement of exhaust fan will be documented. The Executive Director (Administrator) and/or designee will be responsible for monitoring this POC to ensure its successful completion.	