STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155383	A. BUILDING -- B. WING	05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON HEALTHCARE CENTER	8201 W WASHINGTON ST INDIANAPOLIS, IN 46231

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/25/22 Facility Number: 000393 Provider Number: 155383 AIM Number: 100289340 At this Emergency Preparedness survey, Washington Healthcare Center was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 91 certified beds. At the time of the survey, the census was 43. Quality Review completed on 05/31/22	E 0000	The submission of this plan of correction does not indicate an admission by Washington Healthcare that the findings and allegations contained herein are an accurate and true representation of the quality of care provided to the residents of this facility. This facility recognizes its obligation to provide legally and medically necessary care and service in a safe environment to its residents in an economic and safe manner. The facility herby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only. *This facility respectfully requests from the Department a desk review for paper compliance. The facility will provide additional information as needed to identify compliance including audit tools, receipts for items corrected and or pictures of before and after corrections.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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E 0035 SS=C Bldg. --	483.475(c)(8), 483.73(c)(8) LTC and ICF/IID Sharing Plan with Patients §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. Based on record review and interview, the facility failed to ensure the emergency preparedness plan (EPP) includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.75(c)(8). This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Executive Director and fill-in Maintenance Supervisor on 05/25/22 between 10:00 a.m. and	E 0035	The facility will ensure this requirement is met through the following actions. POTENTIAL TO BE AFFECTED: All residents, family members and visitors have the potential to be impacted by this alleged deficient practice, however none were. CORRECTIVE ACTIONS COMPLETED: On June 6, 2022 the Executive Director posted in common area of facility a notice to residents and	06/10/2022

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	12:50 p.m., the Emergency Preparedness Binder provided did not address a method for sharing information contained within the EPP Binder that the facility deems appropriate with clients, their families or representatives. Based on interview at the time of records review, the Administrator telephoned the corporate office and was told that the documentation provided is what they have always used. Documentation provided addresses how and when the facility would contact families and representatives in the event of an emergency, but did not declare when, where and how residents, families or representatives could view the EPP documentation the facility deemed appropriate if they so decided. The provided documentation only suggested they call the facility if they had questions. The finding was reviewed with the acknowledged by the fill-in Maintenance Supervisor at the time of discovery and again at the exit conference with the Executive Director and fill-in Maintenance Supervisor present at 4:30 p.m.		family members and visitors that the emergency preparedness plan is available for review upon request to the Executive Director. MEASURES TO PREVENT REOCCURENCE: The Activity Director will also review 06/2022 in Resident Council and yearly thereafter that EPP is available for review upon request to the Executive Director. Signage will be maintained with isdh postings. HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The Executive Director will insure that continued posting will be maintained in visible area. If there are any issues with posting, they will be addressed and resolved immediately. The issues will then be brought to the Quality Assurance Committee at that time. If needed and Action Plan will be recommended and then monitored by the Executive Director.	
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: 05/25/22	K 0000	The submission of this plan of correction does not indicate an admission by Washington Healthcare that the findings and allegations contained herein are an accurate and true	

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	Facility Number: 000393 Provider Number: 155383 AIM Number: 100289340 At this Life Safety Code survey, Washington Healthcare 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. This one-story facility was determined to be of Type V (111) 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 in all resident sleeping rooms. The facility has a capacity of 91 and had a census of 43 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached building for storage of supplies which was not sprinklered. Quality Review completed on 05/31/22		representation of the quality of care provided to the residents of this facility. This facility recognizes its obligation to provide legally and medically necessary care and service in a safe environment to its residents in an economic and safe manner. The facility herby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only. *This facility respectfully requests from the Department a desk review for paper compliance. The facility will provide additional information as needed to identify compliance including audit tools, receipts for items corrected and or pictures of before and after corrections.	
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			

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	LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be 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			

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	ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure all means of egress 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 15, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview during a tour of the facility with the Executive Director and fill in Maintenance Supervisor 05/25/22 between 12:50 p.m. and 3:30 p.m., the exit door at the main entrance was marked as a facility exit, was magnetically locked and could be opened by entering a four digit code but the code was not posted at the exit.	K 0222	It is the policy of this facility to insure doors within a required means of egress shall not be equipped with a latch or lock that requires the use o a tool, key or code from the egress side unless otherwise permitted to meet set standards. POTENTIAL TO BE AFFECTED: Residents, staff and visitors have the potential to be impacted by this alleged deficient practice, however none were. CORRECTIVE ACTIONS COMPLETED: On October 6, 2022 the Executive Director posted the correct code at the exit door to exit the facility at the main entrance. On October 6, 2022 the Executive Director in-serviced the Maintenance	06/10/2022

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	The finding was reviewed with the acknowledged by the fill in Maintenance Supervisor at the time of discovery and again at the exit conference with the Executive Director and fill in Maintenance Supervisor present at 4:30 p.m. 3.1-19(b)		Director on the requirement that all exit doors must have the correct code posted to meet the standards and that monthly inspections are completed on all egress doors to assure exit codes are posted. If the maintenance director fails to comply with the points of the in-service further education and or progressive discipline as needed will be completed. MEASURES TO PREVENT REOCCURENCE: The Maintenance Supervisor/or designee will review the codes for all exit doors throughout the facility 1x monthly x's 12 months to insure the correct codes are posted as part of the facilities preventative maintenance program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The maintenance supervisor will review with the Executive Director the inspection results. HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The Executive Director will monitor adherence to the Preventative Maintenance schedule and validate the "Preventative Maintenance Egress Doors" 1x	

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			monthly x's 12 months. The results of the audit will be presented by the Executive Director monthly for review in the monthly QAPI meeting. Frequency and duration of the audits will be adjusted as needed or recommended by the QA team.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons)			

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	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 failed to ensure all hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 10 residents, as well as staff and visitors. Findings include: Based on observations and interview during a tour of the facility with the Executive Director and fill in Maintenance Supervisor 05/25/22 between 12:50 p.m. and 3:30 p.m., the following was noted: A) Room 210, greater than 50 square feet, contained a number of combustible items, such as, paper, plastic, and more than 50 cardboard boxes. The room not equipped with a self-closing device or self-closing hinges. B) Room 211, greater than 50 square feet, had cardboard boxes and various Christmas decorations stored inside the room. The room not equipped with a self-closing device or self-closing hinges. C) Room 212, greater than 50 square feet, had covid test supplies and cardboard boxes. The room not equipped with a self-closing device or self-closing hinges. D) Room 201, greater than 50 square feet, contained boxes and mattresses. The room not equipped with a self-closing device or self-closing hinges.	K 0321	It is the intent of this facility to assure that all hazardous rooms are equipped with a self-closing device or self-closing hinges. Hazardous rooms are designated as such. POTETIAL TO BE AFFECTED: Residents, staff and visitors have the potential to be impacted by this alleged deficient practice, however none were. These rooms were on a closed secured unit that did not occupy any residents. CORRECTIVE ACTIONS COMPLETED: On 6/6/22 The Executive Director in-serviced the Maintenance and Housekeeping Supervisor/designee on the requirements for storage and using only designated storage areas. A) Room 210, room was organized and some items dispersed to proper storage areas. B) Room 211, all cardboard boxes and various Christmas decorations were removed from the room. The room is now set up for a resident. C) Room 212 all covid test supplies and cardboard boxes were removed from the room. The	06/10/2022

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	The finding was reviewed with the acknowledged by the fill in Maintenance Supervisor at the time of discovery and again at the exit conference with the Executive Director and fill in Maintenance Supervisor present at 4:30 p.m. 3.1-19(b)		room is now set up for a resident. D) Room 201, all contained boxes and mattresses were removed from the room. The room is now set up for a resident. MEASURES TO PREVENT REOCCURRENCE: Executive Director/or designee will do a daily inspection of secured unit 5's week x's 30 days, then 2x weekly x's 4 weeks then 1 x weekly x's 8 weeks HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The Executive Director will forward the inspection results to the Quality Assurance Team monthly The results of the audit will be presented by the Executive Director for review in the monthly QAPI meeting. Frequency and duration of the audits will be adjusted as needed or recommended by the QA team.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.			

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	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 observation and interview, the facility failed to maintain the ceiling construction throughout the facility. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect 4 residents and 3 staff. Findings include: Based on observations and interview during a tour of the facility with the Executive Director and fill in Maintenance Supervisor 05/25/22 between 12:50 p.m. and 3:30 p.m., in the common area in the LTC side, there were a 1-inch unsealed gaps around the sprinkler heads. This condition could delay the activation of the sprinklers. Based on interview at the time of observation, the Maintenance Supervisor agreed there were unsealed gaps in the ceiling around the sprinkler head. The finding was reviewed with the acknowledged by the fill in Maintenance Supervisor at the time of discovery and again at the exit conference with the Executive Director and fill in	K 0353	It is the intent of this facility that Sprinkler System- Maintenance and Testing Automatic sprinkler and system are inspected, tested and maintained in accordance NFPA 25 and assure that all sprinkler heads are not covered with foreign material in accordance with LSC 9.7.5 and 5.2.1.1.1 POTENTIAL TO BE AFFECTED: Residents, staff and visitors have the potential to be impacted by this alleged deficient practice, however none were. CORRECTIVE ACTIONS COMPLETED: On 6/10/22 the sprinkler head found in common area on the ltc side was re-secured to close gap between the head and ceiling. On 6/10/22 the sprinkler heads in the laundry area were inspected and cleaned by the the Maintenance Director. MEASURES TO PREVENT REOCCURRENCE:	06/10/2022

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	Maintenance Supervisor present at 4:30 p.m. 2. Based on observation and interview, the facility failed to ensure all sprinkler heads were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 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: (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. This deficient practice could affect staff and up to 3 staff in the laundry area. Findings include: Based on observations and interview during a tour of the facility with the Executive Director and fill in Maintenance Supervisor 05/25/22 between 12:50 p.m. and 3:30 p.m., the sprinkler heads in the laundry area were covered in dust or showed signs of loading. The finding was reviewed with the acknowledged by the fill in Maintenance Supervisor at the time of discovery and again at the exit conference with the Executive Director and fill in Maintenance Supervisor present at 4:30 p.m. 3.1-19(b)		Maintenance Supervisor was in-serviced on 6/9/22 by the Executive Director on the requirement of the sprinkler heads and system visual inspections. Maintenance Director or designee will do a visual inspection of all sprinkler heads to include couplings to ensure that the devices are free from dust and secured with no gap from ceiling to sprinkler 3x's week x's 4 weeks then 1x weekly x 8 weeks then 1x monthly x's 9 months HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The inspection results will be presented to the Quality Assurance Team monthly by the Executive Director. Frequency and duration of the audits will be adjusted as needed or recommended by the QA team upon review.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers			

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(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
	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 Based on observation and interview, the facility failed to inspect all portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using pushto-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall	K 0355	It is the intent of this facility that all fire extinguishers have the annual inspection completed and manual inspections completed and documented monthly. POTENTIAL TO BE AFFECTED: Residents, staff and visitors have the potential to be impacted by this alleged deficient practice, however none were. CORRECTIVE ACTIONS COMPLETED: The fire extinguisher in the courtyard was removed and will not be replaced d/t this is not a smoking area any longer and facility is non smoking. The cooking grill in this area was relocated to unattached picnic area by employee parking lot. MEASURES TO PREVENT REOCCURRENCE: Maintenance Supervisor was in-serviced on 6/9/22 by the Executive Director on the requirement of monthly manual fire extinguisher inspections. Maintenance Director or designee will do a visual/manual inspection of all fire extinguishers 1x monthly x's 12 months with the inspection	06/10/2022

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	be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect 8 residents and 4 staff in the courtyard. Findings include: Based on observations and interview during a tour of the facility with the Executive Director and fill in Maintenance Supervisor 05/25/22 between 12:50 p.m. and 3:30 p.m., the monthly and annual inspection tag on the ABC fire extinguisher located in the courtyard lacked documentation of recent monthly inspections or an annual tag since September of 2019. The vender for the facility is now Whitlock, the annual tag reflected Nelbud which the facility hasn't used in a couple years. The fill in Maintenance Supervisor stated that this extinguisher had been missed by the contractor and by the facility since 9/19. The finding was reviewed with the acknowledged by the fill in Maintenance Supervisor at the time of discovery and again at the exit conference with the Executive Director and fill in Maintenance Supervisor present at 4:30 p.m. 3.1-19(b)		results with facility map locations of all extinguishers given to the Executive Director for review. HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The Executive director will review the audit tool and then present the audit tool with the inspections to the Quality Assurance Team monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the QA team.	
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			

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	compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	1. 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 6 staff and 15 residents.	K 0363	It is the intent of this facility that all corridor doors have no impediment to closing and latching into the door frame and no open passages that would impede the ability to resist the passage of smoke.	06/10/2022

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	Findings include: Based on observations and interview during a tour of the facility with the Executive Director and fill in Maintenance Supervisor 05/25/22 between 12:50 p.m. and 3:30 p.m., the following corridor doors failed to latch positively into their respective door frames: a) The Nourishment Pantry Door on the LTC side, equipped with a self-closing device. b) The Housekeeping room on the LTC side, equipped with a self-closing device. c) The bathing shower rooms on the (1) LTC and (2) the Therapy side, equipped with a self-closing device. d) Storage room by the nurse's station on the LTC side, equipped with a self-closing device. e) The Mechanical room across from the conference room on the LTC side, equipped with a self-closing device. The finding was reviewed with the acknowledged by the fill in Maintenance Supervisor at the time of discovery and again at the exit conference with the Executive Director and fill in Maintenance Supervisor present at 4:30 p.m. 2. Based on observation and interview, the facility failed to ensure all corridor doors would resist the passage of smoke. This deficient practice could affect 15 residents in the dining area. Findings include: Based on observations and interview during a tour of the facility with the Executive Director and fill in Maintenance Supervisor 05/25/22 between 12:50 p.m. and 3:30 p.m., the kitchen door into the memory care dining area had holes		POTENTIAL TO BE AFFECTED: Residents, staff and visitors have the potential to be impacted by this alleged deficient practice, however none were. CORRECTIVE ACTIONS COMPLETED: a) The Nourishment Pantry Door on the LTC side is equipped with a self-closing device. This device was adjusted to allow full closure of door to allow a complete latch. b) The Housekeeping room on the LTC side equipped with a self-closing device. This device was adjusted to allow full closure of door to allow a complete latch. c) The bathing shower room on the (1)LTC and (2)the Therapy Side, is equipped with a self closing device. This device was adjusted to allow full closure of door to allow a complete latch. d) The Storage room by the nurses station on the LTC side is equipped with a self-closing device. This device was adjusted to allow full closure of door to allow a complete latch. e) The Mechanical room across from the conference room on the LTC side, equipped with a self closing device. This device was adjusted to allow full closure of door to allow a complete latch. 2. Kitchen door into memory care dining area holes that penetrated completely through the door have	

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	which penetrated completely through the door, approximately ½ inch and would not resist the passage of smoke. The finding was reviewed with the acknowledged by the fill in Maintenance Supervisor at the time of discovery and again at the exit conference with the Executive Director and fill in Maintenance Supervisor present at 4:30 p.m. 3.1-19(b)		been filled with fire caulk. MEASURES TO PREVENT REOCCURRENCE: Maintenance Supervisor was in-serviced on 6/9/22 by the Executive Director on the requirement of responsibility to assure that all corridor doors have no impediment to closing and latching into the door frame to allow resistance of smoke of the passage of smoke. Maintenance Director or designee will do a visual/manual inspection of all self closing doors 1x weekly x's 3 months then 1x monthly x's 9 months with the inspection results given to the Executive Director for review. HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The Executive director will review the audit tool and then present the audit tool with the inspections to the Quality Assurance Team monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the QA team.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING			

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	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 unsealed holes in 1 of 1 ceiling smoke barriers were protected to maintain the smoke resistance of the ceiling 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. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 20 residents near the entrance to the memory care unit. Findings include: Based on observations and interview during a tour of the facility with the Executive Director	K 0372	It is the intent of this facility that roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. POTENTIAL TO BE AFFECTED: Residents, staff and visitors have the potential to be impacted by this alleged deficient practice, however none were. CORRECTIVE ACTIONS COMPLETED: The ceiling in the corridor near the entrance to the memory care unit had a ceiling tile placed to cover the access point to the attic. MEASURES TO PREVENT REOCCURRENCE: Maintenance Supervisor was in-serviced on 6/9/22 by the Executive Director on the requirement of smoke barrier assembly Maintenance Director or designee will do a visual/manual	06/10/2022

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	and fill in Maintenance Supervisor 05/25/22 between 12:50 p.m. and 3:30 p.m., the ceiling in the corridor near the entrance to the memory care unit a hole approximately 24 X 24 Inches. It appeared to be an unfilled attic access point. The finding was reviewed with the acknowledged by the fill in Maintenance Supervisor at the time of discovery and again at the exit conference with the Executive Director and fill in Maintenance Supervisor present at 4:30 p.m. 3.1-19(b)		inspection of ceilings throughout all corridors 1x monthly x's 12 months with the inspection results given to the Executive Director. HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The results of the audit will be presented by the Executive Director for review in the monthly QAPI meeting. Frequency and duration of the audits will be adjusted as needed or recommended by the QA team.	
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 all sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in	K 0374	It is the intent of this facility that all smoke barrier will restrict the movement of smoke for at least 20 min an shall close the opening	06/10/2022

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	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 12 residents and 6 staff. Findings include: Based on observations and interview during a tour of the facility with the Executive Director and fill in Maintenance Supervisor 05/25/22 between 12:50 p.m. and 3:30 p.m., the set of double smoke barrier doors near room 312 did not close completely and latch. Based on interview during the time of observations, the Executive Director acknowledged these smoke barrier doors did not close completely and latch. The finding was reviewed with the acknowledged by the fill in Maintenance Supervisor at the time of discovery and again at the exit conference with the Executive Director and fill in Maintenance Supervisor present at 4:30 p.m. 3.1-19(b)		leaving only the minimum clearance necessary for proper operation. POTENTIAL TO BE AFFECTED: Residents, staff and visitors have the potential to be impacted by this alleged deficient practice, however none were. CORRECTIVE ACTIONS COMPLETED: The smoke barrier doors near room 312 was adjusted so that when released the doors would close completely and latch. MEASURES TO PREVENT REOCCURRENCE: Maintenance Supervisor was in-serviced on 6/9/22 by the Executive Director on the requirement of responsibility to assure all doors are checked that are a smoke barrier and will restrict the movement of smoke for at least 20 min and shall close the opening leaving only the minimum clearance necessary for proper operation. Maintenance Director or designee will do a visual/manual inspection of all smoke barrier corridor doors 1x weekly x's 3 months then 1 time monthly x's 9 months with the inspection results given to the Executive Director for review. HOW THE CORRECTIVE ACTIONS WILL BE MONITORED	

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			TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The Executive director will review the audit tool and then present the audit tool with the inspections to the Quality Assurance Team monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the QA team.	
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 1. Based on observation and interview, the facility failed to ensure all electrical panels in the corridors were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect staff and 30 residents.	K 0511	It is the intent of this facility that all electrical panels in the corridors are secured from non-authorized personnel and all electrical junction boxes in the facility are maintained in a safe operating condition. POTENTIAL TO BE AFFECTED: Residents, staff and visitors have the potential to be impacted by this alleged deficient practice, however none were. CORRECTIVE ACTIONS COMPLETED: (1)The 2 electrical panels near the nurse's station on the LTC side hall are now locked	06/10/2022

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	Findings include: Based on observations and interview during a tour of the facility with the Executive Director and fill in Maintenance Supervisor 05/25/22 between 12:50 p.m. and 3:30 p.m., (1) two electrical panels near the nurse's station on the LTC side hall were unlocked when tested. And (2) one electrical panel in the memory/dementia care hall was not locked when tested. The finding was reviewed with the acknowledged by the fill in Maintenance Supervisor at the time of discovery and again at the exit conference with the Executive Director and fill in Maintenance Supervisor present at 4:30 p.m. 2. Based on observation, the facility failed to ensure all electrical junction boxes in the facility were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect 4 staff and 14 residents in the 100 hall and soiled utility area. Findings include: Based on observations and interview during a tour of the facility with the Executive Director and fill in Maintenance Supervisor 05/25/22 between 12:50 p.m. and 3:30 p.m., (1) several electrical junction boxes above the ceiling by the		(2) The electrical panel in the memory care hall is now locked (1) The electrical junction boxes above the ceiling by the florescent lights on the 100 hall have been re-secured. (2) The electrical junction box in the soiled utility area on the Rehab side near the water inlet has had a cover placed and is now not exposing the electrical wiring. MEASURES TO PREVENT REOCCURRENCE: Maintenance Supervisor was in-serviced on 6/9/22 by the Executive Director on the requirement that all electrical panels in the corridors are secured from non-authorized personnel and that all electrical junction boxes in the facility are maintained in a safe operating condition. Maintenance Director or designee will do a visual/manual inspection of all electrical panels and junction boxes in facility areas to assure they are secured 1x weekly x's 3 months then 1 time monthly x's 9 months with the inspection results given to the Executive Director for review. HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The Executive director will review	

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	florescent lights on the 100 hall and (2) one electrical junction box in the Soiled Utility Area on the Rehab side near the water inlet, did not contain a cover and had exposed electrical wiring The finding was reviewed with the acknowledged by the fill in Maintenance Supervisor at the time of discovery and again at the exit conference with the Executive Director and fill in Maintenance Supervisor present at 4:30 p.m. 3.1-19(b)		the audit tool and then present the audit tool with the inspections to the Quality Assurance Team monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the QA team.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills or documented orientation training on each shift for 2 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. QSO-20-31 1135 temporary waiver states in lieu of a physical fire drill, a documented orientation training program related to the current fire plan, which considers	K 0712	It is the intent of this facility that fire drills are conducted and documented orientation training on each shift all 4 quarters. POTENTIAL TO BE AFFECTED: All residents have potential to be affected by this alleged deficient practice, however none were. CORRECTIVE ACTIONS COMPLETED: All staff was	06/10/2022

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	current facility conditions, is acceptable. The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area. This deficient practice affects all occupants. Findings include: Based on record review and interview with the Executive Director and fill in Maintenance Supervisor on 05/25/22 between 10:00 a.m. and 12:50 p.m., the following shifts were missing documentation of a completed fire drill or documented orientation training: a) Third Shift first quarter 2022. b) First and Third Shifts, Third quarter of 2021. The finding was reviewed with the acknowledged by the fill in Maintenance Supervisor at the time of discovery and again at the exit conference with the Executive Director and fill in Maintenance Supervisor present at 4:30 p.m. 3.1-19(b) 3.1-51(c)		in-serviced on fire drills and Maintenance Supervisor was in-serviced on 6/9/22 by the Executive Director on the requirement for fire drills, logging drill into tels and assuring a in-service log is signed by all staff participating. MEASURES TO PREVENT REOCCURRENCE: Maintenance Director or designee will run fire drills 1x per shift per month and log drill into tels. The Director will also assure that In-service sheets are signed by all participating employee. These sheets will then be given to the Executive Director for review. HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The Executive director will review the audit tool and then present the audit tool with the inspections to the Quality Assurance Team monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the QA team.	
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:			

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	155383	A. BUILDING 01 B. WING	05/25/2022

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	(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 observation, records review, and interview, the facility failed enforce 1 of 1 non-smoking policies. This deficient practice could affect 5 staff around the shelter area. Findings include: Based on observations and interview during a tour of the facility with the Executive Director and fill in Maintenance Supervisor 05/25/22 between 12:50 p.m. and 3:30 p.m., smoking on property was evident due to at least 25 cigarette butts around the shelter area outside. Based on records review the smoking policy stated	K 0741	It is the intent of this facility to follow the facility smoke free policy. POTENTIAL TO BE AFFECTED: All residents, visitors and staff have potential to be affected by this alleged deficient practice, however none were. CORRECTIVE ACTIONS COMPLETED: All staff was in-serviced on smoke free policy.	06/08/2022

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	smoking is not allowed on the facility's property. The finding was reviewed with the acknowledged by the fill in Maintenance Supervisor at the time of discovery and again at the exit conference with the Executive Director and fill in Maintenance Supervisor present at 4:30 p.m. 3.1-19(b)		MEASURES TO PREVENT REOCCURRENCE: Maintenance Director or designee will walk through parking lot 1x daily x's 5 days x's 3 months then 1x weekly x's 9 months to assure that there is no evidence of staff or visitors smoking on property. Any cigarette butts found will be addressed and cleaned up at that time. HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The Executive director will review the audit tool and then present the audit tool with the inspections to the Quality Assurance Team monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the QA team.	
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			

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	do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5			
	1. Based on observation and interview, the facility failed to ensure the facility did not used multi-plug adaptors as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects 4 staff. Findings include: Based on observations and interview during a tour of the facility with the Executive Director and fill in Maintenance Supervisor 05/25/22 between 12:50 p.m. and 3:30 p.m., the (1) maintenance office contained a multi-plug adaptor powering equipment near the corridor door. And (2) the payroll office contained an multi-plug adaptor powering various equipment behind the computer screen. The finding was reviewed with the acknowledged	K 0920	It is the intent of this facility to not utilize multi-plug adaptors POTENTIAL TO BE AFFECTED: All residents and staff have potential to be affected by this alleged deficient practice, however none were. CORRECTIVE ACTIONS COMPLETED: All staff was in-serviced on 6/8/22 regarding the non-use of multi-plug adaptors. The 2 adaptors found during LS tour were removed immediately. MEASURES TO PREVENT REOCCURRENCE: Maintenance Director or designee will walk through common areas and offices 1x daily x's 5days x's 3 months then 1x weekly x's 9 months to assure that there is no	06/10/2022

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	by the fill in Maintenance Supervisor at the time of discovery and again at the exit conference with the Executive Director and fill in Maintenance Supervisor present at 4:30 p.m. 2. Based on observation and interview, the facility failed to ensure all power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 2 staff in the schedulers office. Findings include: Based on observations and interview during a tour of the facility with the Executive Director and fill in Maintenance Supervisor 05/25/22 between 12:50 p.m. and 3:30 p.m., in the Schedulers Office a power strip was being used to power a dorm style refrigerator (high power draw equipment). The finding was reviewed with the acknowledged by the fill in Maintenance Supervisor at the time of discovery and again at the exit conference with the Executive Director and fill in Maintenance Supervisor present at 4:30 p.m. 3.1-19(b)		evidence of staff utilizing multi-plug adaptors smoking on property. Any adaptors found will be removed and the staff member will be re-educated on non-use. HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The Executive director will review the audit tool and then present the audit tool with the inspections to the Quality Assurance Team monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the QA team.	
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			

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	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 storage room where oxygen transferring takes place, was provided with properly working mechanical ventilation. NFPA 99 2012 edition, 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical exhaust to maintain a negative pressure in the space continuously. This deficient practice could affect 18 residents in one smoke compartment. Findings include: Based on observations and interview during a tour of the facility with the Executive Director and fill in Maintenance Supervisor 05/25/22 between 12:50 p.m. and 3:30 p.m., the oxygen storage/transfer room contained large liquid oxygen tanks. There was one vent in the room, but it did not appear to be working and when tested with paper, did not appear to be exhausting to the outside. The finding was reviewed with the acknowledged by the fill in Maintenance Supervisor at the time of discovery and again at the exit conference with the Executive Director and fill in Maintenance Supervisor present at 4:30 p.m. 3.1-19(b)	K 0927	It is the intent of this facility to ensure that the oxygen storage room where oxygen transferring takes place is provided with properly working mechanical ventilation POTENTIAL TO BE AFFECTED: All residents and staff have potential to be affected by this alleged deficient practice, however none were. CORRECTIVE ACTIONS COMPLETED: Vent in the oxygen storage room was replaced with a working one. MEASURES TO PREVENT REOCCURRENCE: Maintenance Director or designee visually inspect the oxygen storage room 1x daily x's 5 days x's 3 months then 1x weekly x's 9 months to assure that the ventilation fan is in working order. The Maintenance Director will then give these Audit tools to the Executive Director.	06/10/2022

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