

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/09/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155364	X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____	X3) DATE SURVEY COMPLETED  07/23/2024
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NAME OF PROVIDER OR SUPPLIER  BYRON HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 1661 BEACON STREET FORT WAYNE, IN 46805
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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: 07/23/24  Facility Number: 000255 Provider Number: 155364 AIM Number: 100273280  At this Emergency Preparedness Survey, Byron Health Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 120 and had a census of 104 at the time of this survey.  Quality Review completed on 07/29/24	E 0000		
K 0000  Bldg. 02	A Life Safety Code survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).  Survey Date: 07/23/24  Facility Number: 000255 Provider Number: 155364 AIM Number: 100273280  At this Life Safety Code Survey, Byron Health Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a),	K 0000	This Plan of Correction is Byron Health Center's credible allegation of compliance. It is the intention of Byron Health Center to be in complete compliance with all Federal and State guidelines. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the state deficiencies. The plan of correction is prepared and/or executed because the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sarah Starcher	Executive Director/COO	08/09/2024

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosed 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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	<p>Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridors, and in resident sleeping rooms. The facility consists of five (5) one-story comprehensive care wings and one (1) two-story residential care wing separated by a two-hour fire barrier, all connecting to a common services core. The building is partially protected by a type II ESS 300 kW diesel powered generator. The facility has a capacity of 120 and had a census of 104 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility had a detached maintenance building that was not sprinklered.</p> <p>Quality Review completed on 07/29/24</p>		<p>provisions of federal and state law require it.</p> <p>We are requesting a desk review/paper compliance.</p> <p><b><u>K 222 NFPA 101 Life Safety Code Standards (EGRESS DOORS)</u></b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>The necessary signage for the specified exit door on Swander Lane has been ordered and will be added to the door. (K 222 Attachment 1)</p> <p><b>How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>Residents in the Swander Neighborhood had the potential to be affected by this practice. Other exit doors were inspected for proper signage and all were found to be in compliance.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>All signage is permanently affixed to these doors so no other measure or systemic change needs to be in place.</p> <p><b>How the corrective action(s)</b></p>	

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			<p><b>will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?</b> All signage is permanently affixed to these doors so no other measure or systemic change needs to be monitored. <b>By what date the systemic changes will be completed?</b> August 23, 2024</p> <p><b><u>K 223 NFPA 101 Life Safety Code Standards (Self-closing DOORS)</u></b> <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> The door wedge was removed from the door. <b>How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken?</b> Residents in the affected areas had the potential to be affected. The door wedge was removed. The Director of Environmental Services did a whole home sweep for improper door wedges and wedges were removed. <b>What measures will be put into place or what systemic changes will be made to</b></p>	

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			<p><b>ensure that the deficient practice does not recur?</b> All staff will be educated on self-closing doors and improper use of door wedges. (K 223 Attachment 1) <b>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?</b> The Director of Plant Operations, or their designee, will inspect 25% of self-closing doors monthly to ensure there is no hinderance to the door closing properly. (K 223 Attachment 2). The inspection reports will be discussed in the monthly QAPI meetings. <b>By what date the systemic changes will be completed?</b> August 23, 2024</p> <p><b><u>K 324 NFPA 101 Life Safety Code Standards</u></b> <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p>	

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			<p>All staff will be educated on the location and use of the UL 300 hood system (K324 Attachment 1).</p> <p><b>How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>The UL 300 hood system is located in the kitchen and each kitchenette. All residents had the potential to be affected. All staff will be educated on the use of the UL 300 hood system.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>All staff will be educated on the use of the UL 300 hood system. (K324 Attachment 1).</p> <p><b>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?</b></p> <p>The Director of Plant Operations will instruct all new employees during orientation on the use of the UL 300 and will do two all-staff in-services each year on the use of the UL 300 hood system.</p> <p><b>By what date the systemic changes will be completed?</b></p> <p>August 23, 2024</p>	

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			<p><b><u>K 345 NFPA 101 Life Safety Code Standards</u></b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>A visual inspection of the fire system was conducted (K345 Attachment 1).</p> <p><b>How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>All residents had the potential to be affected. A visual inspection of the fire system was conducted</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>The Director of Plant Operations, or their designee, will perform a visual inspection of the fire system every six months to ensure the system is working properly. (K 345 Attachment 2). The inspection reports will be discussed in the QAPI meetings.</p>	

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			<p><b>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?</b> The Director of Plant Operations, or their designee, will perform a visual inspection of the fire system every six months to ensure the system is working properly. (K 345 Attachment 2). The inspection reports will be discussed in the QAPI meetings.</p> <p><b>By what date the systemic changes will be completed?</b> August 23, 2024</p> <p><b><u>K 363 NFPA 101 Life Safety Code Standards</u></b> <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> The door was adjusted to ensure proper latch.</p> <p><b>How other residents having the potential to be affect by the same deficient practice will be identified and what corrective</b></p>	

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			<p><b>action(s) will be taken?</b> Residents on the Kennedy neighborhood have the potential to be affected by this practice. All resident room doors were inspected to ensure proper latch (K 363 Attachment 1)</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b> The Director of Plant Operations, or their designee, will inspect 20% of all resident doors monthly to ensure proper latching. (K 363 Attachment 2). The inspection reports will be discussed in the QAPI meetings.</p> <p><b>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?</b> The Director of Plant Operations, or their designee, will inspect 20% of all resident doors monthly to ensure proper latching. (K 363 Attachment 2). The inspection reports will be discussed in the QAPI meetings.</p> <p><b>By what date the systemic changes will be completed?</b> August 23, 2024</p>	

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			<p><b><u>K 712 NFPA 101 Life Safety Code Standards</u></b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>An annual schedule of fire drills will be developed and communicated to the Director of Plant Operations and Executive Leadership to ensure monthly fire drills are conducted appropriately each quarter.</p> <p><b>How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>All residents had the potential to be affected by this practice. An annual schedule of fire drills will be developed and communicated to the Director of Plant Operations and Executive Leadership to ensure monthly fire drills are conducted appropriately each quarter.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>The monthly and quarterly reports of fire drills will be reported on in the monthly QAPI meeting to</p>	

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K 0222 SS=E Bldg. 02	<p>NFPA 101 Egress Doors Egress Doors</p> <p>Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING</p> <p>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.</p> <p>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1,</p>		<p>ensure compliance with the regulation (K 712 Attachment 1). <b>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?</b> The Director of Plant Operations will conduct fire drills in accordance with the quarterly shift requirements. The monthly and quarterly reports of fire drills will be reported on in the monthly QAPI meeting to ensure compliance with the regulation <b>By what date the systemic changes will be completed?</b> August 23, 2024</p>	

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	<p>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.</p> <p>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.</p> <p>18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.</p> <p>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</p>			

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	<p>throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 1 delayed egress locks in Swander Hall was readily accessible for all residents, staff, and visitors. LSC 7.2.1.6.1.(3) (4) states a readily visible, durable sign in letters not less than 1 in. (25mm) high and not less than 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS".</p> <p>This deficient practice could affect 25 residents on Swander Hall.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 07/23/24 at 1:08 p.m., the side exit door located on Swander Hall was provided with a delayed egress lock but lacked the proper signage indicating the door can be opened in 15 seconds by pushing on the door. Based on interview at the time of observation, the Maintenance Director agreed the Swander exit door was equipped with a delayed egress and lacked the proper signage.</p> <p>The finding was reviewed with the Administrator and the Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p>	K 0222	<p><b><u>K 222 NFPA 101 Life Safety Code Standards (EGRESS DOORS)</u></b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>The necessary signage for the specified exit door on Swander Lane has been ordered and will be added to the door. (K 222 Attachment 1)</p> <p><b>How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>Residents in the Swander Neighborhood had the potential to be affected by this practice. Other exit doors were inspected for proper signage and all were found to be in compliance.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>All signage is permanently affixed to these doors so no other measure or systemic change needs to be in place.</p> <p><b>How the corrective action(s) will be monitored to ensure the</b></p>	08/23/2024
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K 0223 SS=E Bldg. 02	<p>NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:</p> <ul style="list-style-type: none"> <li>*Required manual fire alarm system; and</li> <li>*Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</li> <li>*Automatic sprinkler system, if installed; and</li> <li>*Loss of power.</li> </ul> <p>18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure 1 of 1 activities hazardous storage room corridor doors in a hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: Required manual fire alarm system; and Local smoke detectors designed to detect smoke passing through the</p>	K 0223	<p><b>deficient practice will not recur i.e., what quality assurance program will be put into place?</b> All signage is permanently affixed to these doors so no other measure or systemic change needs to be monitored. <b>By what date the systemic changes will be completed?</b> August 23, 2024</p> <p><b><u>K 223 NFPA 101 Life Safety Code Standards (Self-closing DOORS)</u></b> <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> The door wedge was removed from the door.</p>	08/23/2024
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NAME OF PROVIDER OR SUPPLIER  BYRON HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 1661 BEACON STREET FORT WAYNE, IN 46805
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K 0324 SS=E	<p>opening or a required smoke detection system; and Automatic sprinkler system, if installed; and Loss of power. This deficient practice could affect 50 residents in one smoke compartment.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 07/23/24 at 11:38 p.m., the activities storage room contained over 30 boxes of craft supplies and was greater than 50 square feet, making this a hazardous area. The door to the room was held open with door wedge which did not release upon activation of the fire alarm system. Based on an interview at the time of observation, the Maintenance Director agreed the storage room contained large amount of combustible storage, was larger than 50 square feet, and was held open with a door wedge.</p> <p>The finding was reviewed with the Administrator and the Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Cooking Facilities</p>		<p><b>How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken?</b> Residents in the affected areas had the potential to be affected. The door wedge was removed. The Director of Environmental Services did a whole home sweep for improper door wedges and wedges were removed.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b> All staff will be educated on self-closing doors and improper use of door wedges. (K 223 Attachment 1)</p> <p><b>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?</b> The Director of Plant Operations, or their designee, will inspect 25% of self-closing doors monthly to ensure there is no hinderance to the door closing properly. (K 223 Attachment 2). The inspection reports will be discussed in the monthly QAPI meetings.</p> <p><b>By what date the systemic changes will be completed?</b> August 23, 2024</p>	

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Bldg. 02	<p><b>Cooking Facilities</b> Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: *residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. *cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or *cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 2 of 5 Kitchenettes. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice affects 50 residents in two smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 07/23/24 at 1:00 p.m. and 1:10 p.m., the kitchenettes in Kennedy Hall and Swander Hall were provided with a UL 300 hood system and a K-class fire extinguisher with posted instructions.</p>	K 0324	<p><b><u>K 324 NFPA 101 Life Safety Code Standards</u></b> <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> All staff will be educated on the location and use of the UL 300 hood system (K324 Attachment 1). <b>How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken?</b> The UL 300 hood system is</p>	08/23/2024
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K 0345 SS=F Bldg. 02	<p>Based on interviews during observations, Certified Nursing Assistant (CNA) #1 and the Dietary staff #1 was asked how to activate the hood suppression system if there was a grease fire underneath the hood. CNA #1 stated she did not know where the pull station to activate the suppression system was located and Dietary staff #1 stated she was unaware of the suppression system. The Maintenance Director acknowledged staffs responses and stated staff will need to be trained on the proper procedures for extinguishing a grease fire on the cooking equipment.</p> <p>The findings were reviewed with the Administrator and the Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.</p>		<p>located in the kitchen and each kitchenette. All residents had the potential to be affected. All staff will be educated on the use of the UL 300 hood system.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b> All staff will be educated on the use of the UL 300 hood system. (K324 Attachment 1).</p> <p><b>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?</b> The Director of Plant Operations will instruct all new employees during orientation on the use of the UL 300 and will do two all-staff in-services each year on the use of the UL 300 hood system.</p> <p><b>By what date the systemic changes will be completed?</b> August 23, 2024</p>	

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	<p><b>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72</b></p> <p>Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 18.3 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually:</p> <ul style="list-style-type: none"> <li>a. Control unit trouble signals.</li> <li>b. Remote annunciators</li> <li>c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.)</li> <li>d. Notification appliances</li> <li>e. Magnetic hold-open devices</li> </ul> <p>This deficient practice affects all occupants in the facility.</p> <p>Findings include:</p> <p>During records review with the Maintenance Director on 07/23/24 at 10:05 a.m., no documentation was provided regarding a visual inspection of the fire alarm system six months prior to the annual fire alarm inspection conducted on 03/19/24. Based on an interview at the time of records review, the Maintenance Director stated a visual inspection of the fire alarm system six months prior to the annual fire alarm inspection was not conducted.</p> <p>This finding was reviewed with the Administrator and Maintenance Director at the exit conference.</p> <p>3.1-19(b)</p>	K 0345	<p><b><u>K 345 NFPA 101 Life Safety Code Standards</u></b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>A visual inspection of the fire system was conducted (K345 Attachment 1).</p> <p><b>How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>All residents had the potential to be affected. A visual inspection of the fire system was conducted</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>The Director of Plant Operations, or their designee, will perform a visual inspection of the fire system every six months to ensure the system is working properly. (K 345 Attachment 2). The inspection reports will be discussed in the QAPI meetings.</p> <p><b>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?</b></p> <p>The Director of Plant Operations, or their designee, will perform a visual inspection of the fire system</p>	08/23/2024

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K 0363 SS=D Bldg. 02	<p>NFPA 101 Corridor - Doors Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and 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 18.3.6.3.6 are permitted.</p> <p>18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of 25 resident room corridor</p>	K 0363	<p>every six months to ensure the system is working properly. (K 345 Attachment 2). The inspection reports will be discussed in the QAPI meetings. <b>By what date the systemic changes will be completed?</b> August 23, 2024</p> <p><b><u>K 363 NFPA 101 Life Safety Code Standards</u></b></p>	08/23/2024

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	<p>doors on Kennedy Hall were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 1 resident in room 217.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 07/23/24 at 12:55 p.m., the corridor door to resident room 217 did not latch into the frame when tested. Based on an interview at the time of observation, the Maintenance Director stated the corridor door would not latch into the door frame when tested.</p> <p>The finding was reviewed with the Administrator and the Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p>		<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> The door was adjusted to ensure proper latch.</p> <p><b>How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken?</b> Residents on the Kennedy neighborhood have the potential to be affected by this practice. All resident room doors were inspected to ensure proper latch (K 363 Attachment 1)</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b> The Director of Plant Operations, or their designee, will inspect 20% of all resident doors monthly to ensure proper latching. (K 363 Attachment 2). The inspection reports will be discussed in the QAPI meetings.</p> <p><b>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?</b> The Director of Plant Operations, or their designee, will inspect 20% of all resident doors monthly to ensure proper latching. (K 363 Attachment 2). The inspection</p>	

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K 0712 SS=F Bldg. 02	<p>NFPA 101 Fire Drills Fire Drills</p> <p>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.</p> <p>18.7.1.4 through 18.7.1.7</p> <p>Based on record review and interview, the facility failed to conduct fire drills on each shift for 3 of 4 quarters. LSC 18.7.1.6 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. This deficient practice affects all staff and residents.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance Director on 07/23/24 at 10:02 a.m., the following shifts were missing documentation of a completed fire drill:</p> <p>a) A second shift fire drill in the first quarter of 2024. b) A second shift fire drill in the second quarter of</p>	K 0712	<p>reports will be discussed in the QAPI meetings.</p> <p><b>By what date the systemic changes will be completed?</b> August 23, 2024</p> <p><b><u>K 712 NFPA 101 Life Safety Code Standards</u></b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>An annual schedule of fire drills will be developed and communicated to the Director of Plant Operations and Executive Leadership to ensure monthly fire drills are conducted appropriately each quarter.</p> <p><b>How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p>	08/23/2024
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	<p>2024.</p> <p>c) A third shift fire drill in the third quarter of 2023. Based on an interview at the time of record review, the Maintenance Director stated there were missing fire drills.</p> <p>This finding was reviewed with the Administrator and Maintenance Director at the exit conference.</p> <p>3.1-19(b) 3.1-51(c)</p>		<p>All residents had the potential to be affected by this practice. An annual schedule of fire drills will be developed and communicated to the Director of Plant Operations and Executive Leadership to ensure monthly fire drills are conducted appropriately each quarter.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>The monthly and quarterly reports of fire drills will be reported on in the monthly QAPI meeting to ensure compliance with the regulation (K 712 Attachment 1).</p> <p><b>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?</b></p> <p>The Director of Plant Operations will conduct fire drills in accordance with the quarterly shift requirements. The monthly and quarterly reports of fire drills will be reported on in the monthly QAPI meeting to ensure compliance with the regulation</p> <p><b>By what date the systemic changes will be completed?</b></p> <p>August 23, 2024</p>		