STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING -- B. WING	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

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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 Dates: 09/15/22 Facility Number: 000095 Provider Number: 155181 AIM Number: 100290490 At this Emergency Preparedness survey, Carmel Health & Living Community was found in compliance with Emergency Preparedness Requirements for Medicare Providers and Suppliers, 42 CFR 483.73 The facility has 188 certified beds and a census of 117. Quality Review completed on 09/22/22	E 0000	October 3, 2022 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: H8LU21 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on September 15, 2022. This letter is to inform you that the plan of correction attached is to serve as Carmel Health & Living Community credible allegation of compliance. We allege substantial compliance on October 10th, 2022. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-445-0548 Sincerely, Alyssa Holliday, HFA	

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

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			Administrator Carmel Health and Living Submission of this plan of correction in no way constitutes an admission by Carmel Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
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 Dates: 09/15/22	K 0000	October 3, 2022 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health	

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	Facility Number: 000095 Provider Number: 155181 AIM Number: 100290490 At this Life Safety Code survey, Carmel Health & Living Community 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 with a partial walkout lower level was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in resident sleeping rooms in the 700 and 800 Hall. The facility has battery operated smoke detectors in resident sleeping rooms in the 200, 300, 400 and 500 Hall. The facility has a capacity of 188 and had a census of 117 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 09/22/22		2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: H8LU21 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on September 15, 2022. This letter is to inform you that the plan of correction attached is to serve as Carmel Health & Living Community credible allegation of compliance. We allege substantial compliance on October 10th, 2022. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-445-0548 Sincerely, Alyssa Holliday, HFA Administrator Carmel Health and Living	

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			Submission of this plan of correction in no way constitutes an admission by Carmel Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 1. Based on observation and interview, the facility failed to maintain latching hardware on 2 of 2 smoke barrier doors in the basement per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect staff and at least 5 staff. Findings include:	K 0100	**K 100** **1. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The Community failed to ensure that 2 sets of	10/02/2022

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	Based on observations during a tour of the facility with the Environmental Director, Assistant Administrator and Executive Director on 09/15/22 between 12:55 p.m. and 3:45 p.m., the set of smoke barrier doors in the basement near (1) the Environmental Services Office and (2) near receiving, were provided with latching hardware but failed to latch when tested. Based on interview at the time of observation, the Environmental Director agreed the doors were not properly latching when tested. This finding was acknowledged at the time of observation and again at the exit conference with the Environmental Director, Assistant Administrator and Executive Director present. 2. Based on observation and interview, the facility failed to ensure 1 of 1 furnace closets in the activities area were free and clear of hazards. NFPA 101 at 19.1.1.3.1 states all health care facilities shall be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect over 10 residents, staff, and visitors in the activities area. Findings include: Based on observations during a tour of the facility with the Environmental Director, Assistant Administrator and Executive Director on 09/15/22 between 12:55 p.m. and 3:45 p.m., the closet in the activities area contained a Gas fired water heater and a furnace. Storage in the aforementioned closet was placed up against the gas fired appliances. The Environmental Director stated that the activities personnel had been told not to		smoke barrier doors in the basement latched properly. The Maintenance Supervisor has reworked these sets of doors and they latch properly. See attached picture labeled “Basement Door Latch” Observation B- The Community failed to ensure that the furnace closet in the activity area was free and clear of hazards. The Maintenance Supervisor has removed the items from this closet. See attached picture labeled “Furnace Room” **2. The facility will identify other residents that may potentially be affected by the deficient practice.** All Residents and staff could be affected by this deficient practice. **3. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a current TELS task to inspect all fire and smoke barrier door monthly to ensure they function properly. See attached task labeled “TELS Door Inspection Task”	

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	store in the closet. This finding was acknowledged at the time of observation and again at the exit conference with the Environmental Director, Assistant Administrator and Executive Director present. 3.1-19(b)		4. **The facility will monitor the corrective action by implementing the following measures.** The Maintenance Supervisor has been reeducated by CarDon Corporate Facilities for the need to ensure that all fire and smoke barrier doors latch properly. They will monitor this documentation during their annual CQR. **5. Plan of Correction completion date.** Plan of Completion date is October 2, 2022.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall 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.			

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	18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 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			

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	on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through several exit doors was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 40, staff and visitors if needing to exit the facility. Findings include: Based on observations during a tour of the facility with the Environmental Director, Assistant Administrator and Executive Director on 09/15/22 between 12:55 p.m. and 3:45 p.m., the following exit doors were magnetically locked and could be opened by entering a four-digit code but the code was either not posted at the exits or the incorrect code was posted at the exits. A) Basement Exit door near Receiving. B) The "Ramp Exit" door. C) Double doors in the independent living apartments back hall. D) Double doors in the independent living apartments 200 hall near the training room. E) Exit door near Resident Room 221. F) Exit door near the Administration area.	K 0222	**K 222** **1. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The Community failed to ensure that basement door near receiving had the proper code posted to operate. The Maintenance Supervisor has posted the code at this location. See attached picture labeled “basement door code”. Observation B- The Community failed to ensure that code was posted by the exit door on the ramp between station 400 and 500. The Maintenance Supervisor has posted the code at this location. Observation C- The Community failed to ensure that the doors leading for he skilled area to assisted living had the proper code posted to operate. The Maintenance Supervisor has posted the code at this location. Observation D- The Community failed to ensure that the double doors on the 200 hall that led to assisted living had the proper code	10/02/2022

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	This finding was acknowledged at the time of observation and again at the exit conference with the Environmental Director, Assistant Administrator and Executive Director present. 3.1-19(b)		posted to operate. The Maintenance Supervisor has posted the code at this location. Observation E- The Community failed to ensure that exit door near resident room 221 had the proper code posted to operate. The Maintenance Supervisor has posted the code at this location. Observation F- The Community failed to ensure that the exit door near the administration area had the proper code posted to operate. The Maintenance Supervisor has posted the code at this location. **2. The facility will identify other residents that may potentially be affected by the deficient practice.** All Residents and staff could be affected by this deficient practice. **3. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a current TELS task to inspect all exit keypads weekly to ensure that they operate correctly, and the codes are posted. See attached task labeled “TELS Exterior Locking System Task”	

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			4. The facility will monitor the corrective action by implementing the following measures. The Maintenance Supervisor has been reeducated by CarDon Corporate Facilities for the need to ensure that all codes are posted properly. They will monitor this documentation during their annual CQR. **5. Plan of Correction completion date.** Plan of Completion date is October 2, 2022.	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 1. Based on observation and interview, the facility failed to ensure 1 of over 10 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect 25 residents.	K 0271	**K 271** **1. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**	12/02/2022

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	Findings include: Based on observations during a tour of the facility with the Environmental Director, Assistant Administrator and Executive Director on 09/15/22 between 12:55 p.m. and 3:45 p.m., the exit discharge near Resident Room 813 had a wooden deck which had deck boards which were warped and uneven, rising more than 18 inches in some locations. The Environmental Director acknowledged that the walkway was in need of repair to have a complete level walking surface that was free of obstructions leading to the common way and that plans were to replace the deck. This finding was acknowledged at the time of observation and again at the exit conference with the Environmental Director, Assistant Administrator and Executive Director present. 2. Based on observation and interview the facility failed to provide an exit discharge from their property to the public way in accordance with the requirements of NFPA 101 - 2012 edition, Sections 19.2, 19.2.1, 19.2.7, 7.1, 3.3.83, 3.3.218, 7.7, 7.7.1 and 7.7.4. This deficient practice could affect approximately 10 residents and staff. Findings include: Based on observations during a tour of the facility with the Environmental Director, Assistant Administrator and Executive Director on 09/15/22 between 12:55 p.m. and 3:45 p.m., the exterior exit door by resident room 713 discharged to a sidewalk that led to the parking lot on the neighboring property. The exit discharge did not lead to the public way. Based on interview at the		Observation A- The Community failed to ensure that path of egress leading from the memory care unit by resident room 813 had a smooth and flat egress. The Maintenance Supervisor has contacted their general contractor to replace the wooden boards along this path. Once completed pictures will be sent to State Life Safety. Observation B- The Community failed to ensure that path of egress from the exit door near resident room 713 discharged to the public way. CarDon Corporate Facilities will be filing a waiver to extend the time period allowed for completion due to time and financial hardship. **2. The facility will identify other residents that may potentially be affected by the deficient practice.** All Residents and staff could be affected by this deficient practice. **3. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**	

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	time of observation, the Environmental Director stated that the facility did not own the property that the exit discharged onto and agreed it did not lead to the public way and at the time of observation the aforementioned sidewalk termination was blocked by cars parked in the neighbors parking lot. This finding was acknowledged at the time of observation and again at the exit conference with the Environmental Director, Assistant Administrator and Executive Director present. 3.1-19(b)		A new TELS task has been created to inspect wooden walkway from memory care unit to the public way. See attached task labeled “TELS Deck Inspection Task” RTM Consultants has reviewed all the egress routes to the 700 Hall. The egress door that leads to a non-public way is not required as an exit. We are going to install the partition wall so that the corridor length is no more than 30’. This work will be completed in the next 30 days. **4. The facility will monitor the corrective action by implementing the following measures.** The Maintenance Supervisor has been reeducated by CarDon Corporate Facilities for the need to ensure that all paths of egress are kept debris free and in good shape. They will monitor this documentation during their annual CQR. **5.** Plan of Correction completion date. Facility deck cited in the tag has been fixed. RTM Consultants has reviewed all the egress routes to the 700 Hall. The egress door that leads to a non-public way is not required as an exit. We are going	

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			to install the partition wall so that the corridor length is no more than 30'. This work will be completed in the next 30 days. Plan of Completion date is December 2nd, 2022	
K 0293 SS=F Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 1 exit signs in the basement was marked with directional indicators to identify the direction of travel to the public way. LSC 7.10.1.2 requires exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. This deficient practice affects all staff and visitors in the basement. Findings include: Based on observations during a tour of the facility with the Environmental Director, Assistant Administrator and Executive Director on 09/15/22 between 12:55 p.m. and 3:45 p.m., the corridor exit sign near the elevator in the basement did not have a directional arrow indicating where the exit door was. No chevrons on the exit sign were	K 0293	**K 293** **1. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The Community failed to ensure that the exit sign in the basement had the proper arrows to identify the path of egress. The maintenance supervisor has reworked the exit sign to show the proper arrow. **2. The facility will identify other residents that may potentially be affected by**	10/02/2022

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	punched out and the sign did not indicate which direction to go toward the exit. This finding was acknowledged at the time of observation and again at the exit conference with the Environmental Director, Assistant Administrator and Executive Director present. 3.1-19(b)		**the deficient practice.** All staff that use the basement could be affected by this deficient practice. **3. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** No follow up needed as this is a permanent solution to the issue. **4. The facility will monitor the corrective action by implementing the following measures.** The Maintenance Supervisor has been reeducated by CarDon Corporate Facilities to ensure that all exit signs have the proper arrows showing the correct path of egress. **5. Plan of Correction completion date.** Plan of Completion date is October 2nd, 2022.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire			

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	155181	A. BUILDING 01 B. WING	09/15/2022

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	barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 1 hazardous area oxygen room doors, were provided with properly working self-closing devices. This deficient practice could affect more than 25 residents, as well as staff and visitors. Findings include:	K 0321	**K 321** **1. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The Community	10/02/2022

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	Based on observations during a tour of the facility with the Environmental Director, Assistant Administrator and Executive Director on 09/15/22 between 12:55 p.m. and 3:45 p.m., the oxygen room door, equipped with a self-closing device, did not self-close and latch into the door frame when tested 3 times. The Environmental Director stated that he had just repaired this door a few weeks ago and was unaware it was still not working properly. The door was unlocked when tested by this surveyor. This finding was acknowledged at the time of observation and again at the exit conference with the Environmental Director, Assistant Administrator and Executive Director present. 3.1-19(b)		failed to ensure that the oxygen room door closed properly and latched on its own. The Maintenance Supervisor has reworked the door to ensure that it latches properly. **2. The facility will identify other residents that may potentially be affected by the deficient practice.** All Residents and staff could be affected by this deficient practice. **3. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a current TELS task to inspect Oxygen Room doors to close and latch properly. See attached task labeled “TELS Oxygen Room Inspection Task” 4. **The facility will monitor the corrective action by implementing the following measures.** The Maintenance Supervisor has been reeducated by CarDon Corporate Facilities to ensure that he knows that all doors need to	

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			close and latch properly. They will monitor this documentation during their annual CQR. **5. Plan of Correction completion date.** Plan of Completion date is October 2, 2022.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation, review and interview, the facility failed to ensure the installation of the sprinkler system met the requirements of NFPA 13. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition; Section 8.6.3.3 Minimum Distances from Walls. Sprinklers shall	K 0351	**K 351** **1. The corrective actions to be accomplished for those residents found to have been affected by the deficient**	10/07/2022

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	be located a minimum of 4 in. from a wall. This deficiency could affect 3 staff in the medical records area. Findings include: Based on observations during a tour of the facility with the Environmental Director, Assistant Administrator and Executive Director on 09/15/22 between 12:55 p.m. and 3:45 p.m., the sprinkler in the basement medical records furnace closet was less than 1-inch from the wall. The close proximity to the wall is noncompliant with the installation requirements of NFPA 13. Based on interview at the time of observation, the Environmental Director stated that he had not noticed that before. This finding was acknowledged at the time of observation and again at the exit conference with the Environmental Director, Assistant Administrator and Executive Director present. 3.1-19(b)		**practice.** Observation A- The Community failed to ensure that the sprinkler head in the basement medical room closet was more than 4 inches from the wall. The Maintenance Supervisor has contacted PIPE Sprinkler to come and re locate the sprinkler head. **2. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff in the basement could be affected by this deficient practice. **3. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation A- There is no follow up needed as this is a permanent solution to the issue. **4. The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect closets for improper	

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			sprinkler head location during their annual CQR. **5. Plan of Correction completion date.** Plan of Completion date is October 7th, 2022	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or 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,			

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	unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 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 26 residents. Findings include: Based on observations during a tour of the facility with the Environmental Director, Assistant Administrator and Executive Director on 09/15/22 between 12:55 p.m. and 3:45 p.m., the following corridor doors failed to latch positively into their respective door frames: a) Central Supply closet in the basement, with self-closing device. b) Resident Room #822 c) Resident Room #712 d) Kitchen door near the elevator. e) Kitchen door into Therapy. f) 500 hall nurses station pantry door. g) Furnace Room #3, with a self-closing device. h) Resident Room #423 I) Supply Room station 3, with Self-closing device. j) Double doors into dialysis near RR 227, with self-closing device.	K 0363	**K 363** **1. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The Community failed to ensure that the central supply closet door latched properly. The Maintenance Supervisor has repaired the door so it would latch properly. Observation B- The Community failed to ensure that resident room 822 door would latch properly. The Maintenance Supervisor has repaired the door. Observation C- The Community failed to ensure that resident room 712 door would latch properly. The Maintenance Supervisor has repaired the door. Observation D- The Community failed to ensure that the kitchen door near the elevator would latch properly. The Maintenance	10/02/2022

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	This finding was acknowledged at the time of observation and again at the exit conference with the Environmental Director, Assistant Administrator and Executive Director present. 3.1-19(b)		Supervisor has repaired the door. Observation E- The Community failed to ensure that the kitchen door into Therapy would latch properly. The Maintenance Supervisor has repaired the door. Observation F- The Community failed to ensure that 500 Hall nurses station pantry door would latch properly. The Maintenance Supervisor has repaired the door. Observation G- The Community failed to ensure that the Furnace room #3 door would latch properly. The Maintenance Supervisor is working with CarDon facilities to replace this door because it has failed. Observation H- The Community failed to ensure that resident room 423 door would latch properly. The Maintenance Supervisor has repaired the door. Observation I- The Community failed to ensure that the Supply Room Door #3 would latch properly. The Maintenance Supervisor has repaired the door. Observation J- The Community failed to ensure that double door near resident room 227 latched properly. The Maintenance Supervisor has repaired the door. **2. The facility will identify other residents that may potentially be affected by the deficient practice.**	

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			All Residents and staff could be affected by this deficient practice. **3. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a current TELS monthly task to inspect all interior doors to ensure that they latch properly. See attached task labeled “TELS Door Inspection Task” **4. The facility will monitor the corrective action by implementing the following measures.** The Maintenance Supervisor has been reeducated by CarDon Corporate Facilities for all doors to close and latch properly. They will monitor this documentation during their annual CQR and during their annual door inspection. **5. Plan of Correction completion date.** Plan of Completion date is October 2, 2022.	

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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 1 of over 10 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. 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, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments	K 0511	**K 511** **1. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The Community failed to ensure that the water machine located in the lobby was more than 3ft away from the nearest outlet. The Maintenance Supervisor has replaced to outlet with a GFCI. Observation B- The Community failed to ensure that the electrical panel near door #4 was unlocked when tested. The Maintenance Supervisor has locked to door on the electrical panel. **2. The facility will identify other residents that may potentially be affected by the deficient practice.** All Residents and staff could be	10/02/2022

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	only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff and 2 residents while at the water machines. Findings include: Based on observations during a tour of the facility with the Environmental Director, Assistant		affected by this deficient practice. **3. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation A- There is no follow up needed as this is a permanent solution to the issue. Observation B- There is a current monthly TELS task to inspect all electrical panels to ensure that they are locked. See attached Task labeled “Electrical Panel Inspection” **4. The facility will monitor the corrective action by implementing the following measures.** The Maintenance Supervisor has been reeducated by CarDon Corporate Facilities the importance to keep electrical panels locked. They will inspect the electrical panels during their annual CQR. **5. Plan of Correction completion date.** Plan of Completion date is October 2, 2022.	

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	Administrator and Executive Director on 09/15/22 between 12:55 p.m. and 3:45 p.m., the water machine in the front lobby was connected to an electric receptacle which was being used power the freestanding water machine, with their own water supply. The water machine was located within 3 feet of an electric receptacle, and not provided with ground fault circuit interruption (GFCI). This finding was acknowledged at the time of observation and again at the exit conference with the Environmental Director, Assistant Administrator and Executive Director present. 2. 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 10 staff and 26 residents. Findings include: Based on observations during a tour of the facility with the Environmental Director, Assistant Administrator and Executive Director on 09/15/22			

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	between 12:55 p.m. and 3:45 p.m., the electrical panel near "door # 4" was unlocked when tested. This finding was acknowledged at the time of observation and again at the exit conference with the Environmental Director, Assistant Administrator and Executive Director present. 3.1-19(b)			
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where			

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	smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview; the facility failed to ensure smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect staff and 10 staff. Findings include: Based on observations during a tour of the facility with the Environmental Director, Assistant Administrator and Executive Director on 09/15/22 between 12:55 p.m. and 3:45 p.m., immediately outside "Door # 4" there were over 30 cigarette butts disposed on the ground in and around the mulch near the building. This finding was acknowledged at the time of observation and again at the exit conference with the Environmental Director, Assistant Administrator and Executive Director present. 3.1-19(b)	K 0741	**K 741** **1. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The Community failed to ensure that the campus smoking policy is being enforced. The Maintenance Supervisor and Administrator has re-educated the staff about the campus smoking policy. **2. The facility will identify other residents that may potentially be affected by the deficient practice.** All Residents and staff could be affected by this deficient practice. **3. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation A- All staff facility in-service conducted on smoking policy. To maintain ongoing compliance the Maintenance Supervisor and Administrator will discuss the smoking policy during	10/02/2022

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			new employee orientation and at morning stand up meetings to ensure it is be enforced. **4. The facility will monitor the corrective action by implementing the following measures.** The Maintenance Supervisor has been reeducated by CarDon Corporate Facilities the importance of keeping the campus smoke free. **5. Plan of Correction completion date.** Plan of Completion date is October 2, 2022.	
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation and interview, the facility failure to ensure 2 of 2 portable space heaters were not used in the building per facility's policy. This deficient practice could affect up to 8 residents, staff and visitors. Findings include: Based on observations during a tour of the facility	K 0781	**K 781** **1. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The Community	10/02/2022

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	with the Environmental Director, Assistant Administrator and Executive Director on 09/15/22 between 12:55 p.m. and 3:45 p.m., a portable space heater was in use in (1) Resident Room 424 B and (2) in the MDS Office. Based on interview at the time of the observation and records review, the Environmental Director agreed a space heater was being used in a resident care area and removed the space heater, agreeing that the use of such heaters did not comply with the faciliy's policy. This finding was acknowledged at the time of observation and again at the exit conference with the Environmental Director, Assistant Administrator and Executive Director present. 3.1-19(b)		failed to ensure that no electric space heaters where in use. The Maintenance Supervisor has removed the space heaters from resident room 424B and the MDS office. **2. The facility will identify other residents that may potentially be affected by the deficient practice.** All Residents and staff could be affected by this deficient practice. **3. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation A- There is a current monthly TELS task to inspect the community to ensure no space heaters are in use. See attached Task labeled “Space Heater Task” **4. The facility will monitor the corrective action by implementing the following measures.** The Maintenance Supervisor has been reeducated by CarDon Corporate Facilities the importance to keep space heaters out of the community. They will	

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			inspect the resident rooms and office during their annual CQR for space heaters in use. **5. Plan of Correction completion date.** Plan of Completion date is October 2, 2022.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 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 1 of 1 flexible cords were not used	K 0920	**K 920**	10/02/2022

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	as a substitute for fixed wiring. 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 3 staff in the basement. Findings include: Based on observations during a tour of the facility with the Environmental Director, Assistant Administrator and Executive Director on 09/15/22 between 12:55 p.m. and 3:45 p.m., in the basement, an orange extension cord what was plugged into an outlet above the garage door opener. The aforementioned cord ran through the wall. The Environmental Director stated he believed the cord powered an outside light. This finding was acknowledged at the time of observation and again at the exit conference with the Environmental Director, Assistant Administrator and Executive Director present. 2. Based on observation and interview, the facility failed to ensure 1 of 1 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 3 residents. Findings include: Based on observations during a tour of the facility with the Environmental Director, Assistant Administrator and Executive Director on 09/15/22 between 12:55 p.m. and 3:45 p.m., a (1) residential refrigerator in the Activities Area and (2) a		**1. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The Community failed to ensure that no extension cords were in use. The basement garage door opener outlet had an extension cord plugged into it leading to an exterior light. The Maintenance Supervisor has removed the extension cord and replaced with permanent wiring. **2. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff that use the basement could be affected by this deficient practice. **3. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation A- There is no follow up needed as this is a permanent fix to the deficiency. **4. The facility will monitor the corrective action by implementing the following**	

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	microwave in Resident Room 201 (high power draw equipment), were plugged into power strips. The Environmental Director stated that the occupants in the facility know better than to do this. This finding was acknowledged at the time of observation and again at the exit conference with the Environmental Director, Assistant Administrator and Executive Director present. 3.1-19(b)		**measures.** The Maintenance Supervisor has been reeducated by CarDon Corporate Facilities the importance to keep extension cords out of the community. **5. Plan of Correction completion date.** Plan of Completion date is October 2, 2022.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen trans-filling rooms were separated from other areas in the facility in a room that is protected with a one-hour fire-resistive construction in accordance with 2012 NFPA 99 11.5.2.3.1(1). This deficient practice could affect 20 residents in one smoke compartment. Findings include:	K 0927	**K 927** **1. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The Community failed to ensure that the oxygen	10/02/2022

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	Based on observations during a tour of the facility with the Environmental Director, Assistant Administrator and Executive Director on 09/15/22 between 12:55 p.m. and 3:45 p.m., the oxygen trans-filling room had a three-inch hole in the wall by the door, possibly where the door knob had gone through the wall. This finding was acknowledged at the time of observation and again at the exit conference with the Environmental Director, Assistant Administrator and Executive Director present. 3.1-19(b)		transfilling room had a 1-hour rating. There was a hole in the wall due to the door handle hitting it. The Maintenance Supervisor has repaired the hole and put a bumper on it so it would not happen again. See attached picture labeled “Oxygen Transfer Room” **2. The facility will identify other residents that may potentially be affected by the deficient practice.** All Residents and staff could be affected by this deficient practice. **3. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation A- There is no follow up needed as this is a permanent solution to the deficiency. **4. The facility will monitor the corrective action by implementing the following measures.** The Maintenance Supervisor has been reeducated by CarDon Corporate Facilities the importance to keep a 1-hour fire	

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			envelope for the oxygen transfilling room. **5. Plan of Correction completion date.** Plan of Completion date is October 2, 2022.	