STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155850	A. BUILDING -- B. WING	09/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELLTOWER HEALTH & REHABILITATION CENTER	5805 NORTH FIR ROAD GRANGER, IN 46530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/05/23 Facility Number: 013644 Provider Number: 155850 AIM Number: 201381180 At this Emergency Preparedness survey, Belltower Health & Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 96 certified beds. At the time of the survey, the census was 78. Quality Review completed on 09/07/23	E 0000	Facility will potentially need to request a temporary waiver for K tag 521	
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: 09/05/23 Facility Number: 013644 Provider Number: 155850 AIM Number: 201381180 At this Life Safety Code survey, Belltower Health	K 0000	Facility will potentially need to request a temporary waiver for K tag 521	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marti Carmean	Administrator	10/05/2023

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

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	and Rehabilitation 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 monitored fire alarm system with hard wired smoke detection in resident rooms, in corridors and in spaces open to the corridors. The facility has a capacity of 96 and had a census of 78 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 09/07/23			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 8 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affect approximately 20 residents and staff in C-Hall. Findings include:	K 0211	1. The beds in the hall way have been removed to ensure an open egress pathway. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be	11/27/2023

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	Based on an observation during a tour of the facility with the Maintenance Director on 09/05/23 between 11:31 a.m. and 12:52 p.m., in the C resident hall near the nurses' station there were two resident beds against the wall protruding into the corridor approximately two feet. Based on an interview at the time of observations, the Maintenance Director stated that the beds were replaced during the weekend and now the beds have to be placed somewhere else for storage. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		affected by the alleged deficient practice. 3. The Maintenance Director has been educated on the requirement as it relates to keeping means of egress open and free of obstacles. This education will be completed by November 27, 2023 · Environmental Rounds will be performed 5 times a week to ensure means of egress and exit pathways are free from obstacles. 4. The maintenance director will audit environmental rounds and forward to QAPI for review, results of those rounds will be reviewed by the QAPI committee monthly for a period of 6-months or until compliance is achieved. 5. Date of Compliance: 11/27/2023	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation and interview, the facility failed to meet the clear width requirement for 1 of 8 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that	K 0232	1. The bench and furniture on the secured memory care unit has been relocated to ensure the corridor is clear and free of obstacles. There were no residents directly affected by the	11/27/2023

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	all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect approximately 12 residents and staff. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 09/05/23 between 11:31 a.m. and 12:52 p.m., the corridor for the memory care wing measured eight feet in clear width. Located within the corridor, there were two chairs and a table in the corridor by the nurses' station that extended approximately 1 foot into the corridor and were not affixed to the floor or to the		alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. The Maintenance Director has been educated on the requirement as it relates to Aisle's and Corridor's with an emphasis on keeping corridors clear. This education will be completed by 11/27/2023 · Environmental rounds will be performed 5 times a week to ensure aisle's and corridors are clear and free of obstacles. 4. The maintenance director will audit environmental and forward to QAPI for review, results of those rounds will be reviewed by the QAPI committee monthly for a period of 6-months or until compliance is achieved. 5. Date of Compliance: 11/27/2023	

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	wall when tested. Furthermore, another chair and table towards the exit door were also not affixed to the floor. Based on interview at the time of the observations, the Maintenance Director agreed the furniture was not affixed to the floor or wall. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities 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 record review, observation and interview; the facility failed to ensure 1 of 1 kitchen fire suppression system was inspected	K 0324	1 1 The vendor for the kitchen suppression system has been contacted the inspection will be	11/27/2023

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	semi-annually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices. Hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect staff in the kitchen and 25 residents in the dining room. Findings include: Based on records review with the Maintenance Director on 09/05/23 between 9:45 a.m. and 11:30 a.m., the most recent kitchen suppression system inspection available for review was dated 01/11/23. An inspection six months after 01/11/23 was not conducted. Based on interview at the time of record review, the Maintenance Director agreed that the only documentation available was from January and further stated that an inspection wasn't conducted six months after 01/11/23. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		completed on or before November 27,2023. There were no residents directly affected by the alleged deficient practice. 2 2 Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3 3 The Maintenance Director & Dietary Manager has been educated on the regulation as it relates to inspections to the suppression system. This educated will be completed by November 27, 2023 The suppression system will be audited every 5 months to ensure the every 6-month requirement is met 4 4 Kitchen Suppression reports will be forwarded to QAPI for review, this will be forwarded to QAPI every 6-months for 12 months 5 5 Date of Compliance November 27, 2023	
K 0345 SS=F Bldg. 01	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,			

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	National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 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 19.3.4.5.1 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: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice affects all occupants in the facility. Findings include: During records review with the Maintenance Director on 09/05/23 between 9:45 a.m. and 11:30 a.m., no documentation was provided regarding a visual inspection of the fire alarm system six months after the annual fire alarm inspection conducted on 11/16/22. Based on 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. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.	K 0345	1. The Vendor has been contacted to perform the 6-month testing for the existing fire panel and facility is awaiting date for completion. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. The Maintenance Director has been educated on the requirement as it relates to fire alarm system testing, this education will be completed by October 20, 2023. 4. Fire alarm system reports will be forwarded to QAPI for review. Results of those findings will be reviewed every 6-months for a period of 12-months or unit compliance is achieved. 5. Date of Compliance October 27, 2023	10/27/2023

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	3.1-19(b)			
K 0353 SS=F 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. 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 record review and interview, the facility failed to maintain 2 of 2 automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests,	K 0353	1 1 The Vendor has been contacted and work to be completed on or before November 27, 2023 that will include the Sprinkler deficiencies noted on the sprinkler report which included, three-year air test, the five-year hydrostatic test, a five-year internal check valve inspection, and automatic drain ball check as well as the dry sprinkler gauges. There were no residents directly affected by the alleged deficient practice. 2 2 Residents residing at the facility have the potential to be	11/27/2023

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	and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on records review on 09/05/23 between 9:45 a.m. and 11:30 a.m., a sprinkler system inspection report titled "Sprinkler System Inspection" dated 04/19/23 indicated five deficiencies were found during the inspection. The report indicated the following: a) The three year air test is due on the 6-inch dry pipe system in risers one and two b) A five year hydrostatic test is due on the 4-inch FDC c) The five year internal check valve inspection is due on the 4-inch FDC grooved swing check valve d) An automatic drain/ball check needs to be added on the dry side of the swing check valve located in the Riser Room for draining water inside FDC piping. Based on interview at the time of record review, the Maintenance Director stated that they had not been fixed due to issues with the renewed contract and was unsure whether the company was supposed to be back out and repair the deficiencies. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 2 of 2 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all		affected by the alleged deficient practice. 3 3 The Maintenance Director has been educated on the requirement as it relates to sprinkler testing, this education will be completed by November 27, 2023 4 4 Sprinkler Testing reports will be forwarded to QAPI for review, results of those reports will be reviewed monthly for a period of 6-months or until compliance is achieved. 5 Date of Compliance November 27, 2023	

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	automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 09/05/23 between 9:45 a.m. and 11:30 a.m., gauge checks for the dry sprinkler system were missing two weeks. The weeks of August 20-26 and August 27- September 2 was not documented on the gauge and valve check sheet titled "Fire Sprinkler Log). Based on interview at the time of record review, the Maintenance Director stated that the inspections were not completed due to them not being recorded on the official document and acknowledged documentation could not be provided to ensure that the inspections were completed. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)			
K 0355 SS=F Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers			

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	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, record review and interview; the facility failed to ensure 18 of 18 portable fire extinguishers were given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on an observation with the Maintenance Director on 09/05/23 between 11:31 a.m. and 12:52 p.m., all tags on all fire extinguishers had an annual inspection date of July 2022. Furthermore, documentation from the company who conducts the annual fire extinguisher inspection during record review, it further indicated that three fire	K 0355	1. 1.The Fire Extinguishers has an annual inspection scheduled on or before November 27, 2023, the K class extinguisher and two additional fire extinguishers have been placed on order and facility waiting for arrival. There were no residents directly affected by the alleged deficient practice. 2 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3 3. The Maintenance Director has been educated on the requirement as it relates to monthly fire extinguisher inspections. This education will be completed by November 27, 2023 Fire extinguisher audits will be conducted monthly by the maintenance director and any found out of compliance will be corrected. 4 4. Fire extinguisher audits will be forwarded to QAPI for review, results of those reports will be reviewed monthly for a period of 6-months or until compliance is achieved. 5 Date of Compliance November 27, 2023	11/27/2023

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	extinguishers failed the annual inspection. No documentation could be provided stating that the extinguishers were replaced/re-inspected. The inspection report stated that the facility needed a 2.5 gallon K-class fire extinguisher and "need new Amb456." Based on interview at the tine of record review and observation, the Maintenance Director stated that the one K-class extinguisher was expired, had the tag removed, and the fire extinguishers were not inspected within the past 12 months. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)			
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review and interview; the facility failed to ensure 46 of 46 fire dampers in the facility were inspected and provided necessary maintenance after the first year after instillation and at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after	K 0521	1 The Smoke Damper inspection has been requested and is waiting for an official date for said inspection the inspection will be completed before November 27, 2023. There were no residents directly affected by the alleged deficient practice. 2 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3 3. The Maintenance Director has been educated on the frequency of smoke damper	11/27/2023

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	155850	A. BUILDING 01 B. WING	09/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELLTOWER HEALTH & REHABILITATION CENTER	5805 NORTH FIR ROAD GRANGER, IN 46530

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	installation. Section 19.4.1.1 states the test and inspection frequency shall be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice can affect all staff, residents and visitors. Findings include: Based on records review with the Maintenance Director on 09/05/23 between 9:45 a.m. and 11:30 a.m., no documentation of an inspection for the smoke/fire dampers within the facility was available for review. During record review, a proposal was provided by the facility to repair and fix all fire dampers within the facility quoted back in January of 2023. Based on interview at the time of records review, the Maintenance Director stated that originally the company had on their schedule to come and do the inspections, but due to some unknown reason the company never came out and none of the dampers were inspected nor repaired. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		inspections. This education will be conducted by the administrator by November 27, 2023 4 4. Smoke Damper inspection reports will be reviewed by the QAPI Committee. These will be reviewed on an annual basis. 5 5. Date of Compliance November 27, 2023	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations			

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	Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on observation and interview, the facility failed to ensure 1 of 1 smoking area was maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect approximately 5 staff and an unknown number of residents. Findings include: Based on observation during a tour of the facility	K 0741	1. The cigarette buts were cleaned up immediately upon the discovery. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. Facility staff has been educated by the administrator on	11/27/2023

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	with the Maintenance Director on 09/05/23 between 11:31 a.m. and 12:52 p.m., in the staff smoking area there were over approximately 30 cigarette butts disposed on the ground in and around the smoking area. Based on interview at the time of observation, the Maintenance Director agree there were cigarette butts on the ground in the aforementioned location and further stated that the facility has a regular cleaning schedule, but acknowledged the numerous amount of cigarette butts on the ground. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		the requirement related to smoking and disposing them in a fire proof container. Maintenance will make daily rounds to ensure items are placed in the proper receptacle. Education will take place by November 27, 2023 4. The Maintenance Director will audit cigarette buts on the ground and report findings to the QAPI for review. This will be reviewed monthly for a period of 6-months or until compliance is achieved. 5. Date of Compliance November 27, 2023	
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, record review and interview; the facility failure to ensure 1 of 1 portable space heater was not used in the facility. This deficient practice could affect approximately 3 staff and an unknown number of residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 09/05/23 between 11:31 a.m. and 12:52 p.m., a portable space heater was located inside of the schedulers	K 0781	1. The space heater was immediately removed upon the discovery. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. Facility staff has been educated by the administrator on space heater use. This education	11/27/2023

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	office. Based on record review between 9:45 a.m. and 11:30 a.m., the facility policy indicated to not allow any space heaters within the facility. Based on interview at the time of observation, the Maintenance Director stated that he was unaware of the space heater and acknowledged that the presence of a space heater was against facility policy. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		will be performed by November 27,2023. Maintenance will conduct weekly rounds to ensure no space heaters are in the facility. 4. Environmental rounds will be forwarded to QAPI monthly for a period of 6-months or until compliance is achieved. 5. Date of Compliance November 27, 2023	