STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING -- B. WING	12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(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(s): 12/06/22 & 12/07/22 Facility Number: 000105 Provider Number: 155198 AIM Number: NA At this Emergency Preparedness survey, Marquette was found not 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 56. Quality Review completed on 12/12/22 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Marquette of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. Marquette reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis of the stated deficiency. This plan of correction serves as the allegation of compliance. Additional supporting documentation will be provided upon request. Marquette respectfully requests a desk review.	
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeffrey Cox	Administrator	01/06/2023

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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MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

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	§485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed,			

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	and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.			
	Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). In the Survey & Certification memo QSO: 19-06-ALL dated 02/01/19, the Centers for Medicare and Medicaid Services (CMS) updated Appendix Z of the State Operations Manual to reflect changes to add emerging infectious diseases to the definition of all-hazards approach and stated "Planning for using an all-hazards approach should also include emerging infectious	E 0006	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to be affected by this practice. Immediately following the Life Safety inspection, an Emerging Infectious Disease (EID) plan was added to the Emergency Preparedness Program in addition to the All-Hazards Risk Assessment. Additionally, EID has been included in the “Types of Emergencies Covered by This Plan” section of the Emergency	02/01/2023

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	disease (EID) threats. Examples of EIDs include Influenza, Ebola, Zika Virus and others". This deficient practice could affect all occupants. Findings include: Based on review of "Disaster Preparedness Manual" documentation dated 10/01/22 with the Administrator and the Building Engineer during record review from 9:35 a.m. to 2:00 p.m. on 12/06/22, a documented facility-based and community-based risk assessment addressing emerging infectious disease (EID) threats was not available for review. EID was not included in the current "Types of Emergencies Covered By This Plan" section of emergency preparedness program documentation for the facility. Based on interview at the time of record review, the Administrator agreed emergency preparedness program documentation did not address emerging infectious diseases (EID) as part of the facility-based and community-based risk assessment as mandated by the CMS Survey & Certification memo QSO: 19-06-ALL. This finding was reviewed with the Administrator and the Building Engineer during the exit conference.		Preparedness binder. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents have the potential to be affected by this practice. Immediately following the inspection, an Emerging Infectious Disease plan was incorporated into the facility's Emergency Preparedness Program. Specific language about EIDs has also been included in the facility's emergency preparedness and infection control documentation and communicated to staff. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Facility management will maintain the Emergency Preparedness Plan that complies with Federal, State, and local laws. Additionally, the Emergency Preparedness Plan and All-Hazards Risk Assessment will be reviewed and updated annually to ensure all required information is included and accurate. Education will be provided to staff regarding EID and Emergency Preparedness. **How will the corrective action be monitored to ensure the**	

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			deficient practice will not recur, i.e. what quality assurance program will be put into place? Annual review of the Emergency Preparedness Plan will be completed by Plant Director or designee to ensure that all required information is included in the program. Additionally, in-servicing on the requirements of the Emergency Preparedness Plan will be completed with facility staff. The results of the annual reviews of the Emergency Preparedness Plan will be shared with the facility's Quality Assurance Performance Improvement Committee for additional recommendations as necessary. **Compliance Date: February 1, 2023**	
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(s): 12/06/22 & 12/07/22 Facility Number: 000105 Provider Number: 155198 AIM Number: NA At this Life Safety Code survey, Marquette was	K 0000	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Marquette of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. Marquette reserves the right to challenge in legal proceedings, all deficiencies, statements,	

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	found not in compliance with Requirements for Participation in Medicare, 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 two story building with a basement was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 96 and had a census of 56 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 12/12/22		findings, facts and conclusions that form the basis of the stated deficiency. This plan of correction serves as the allegation of compliance. Additional supporting documentation will be provided upon request. Marquette respectfully requests a desk review.	
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. Based on observation and interview, the facility failed to ensure 1 of 1 corridor door sets to the second floor dining room would self close and latch into the door frame 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	K 0100	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to be	02/01/2023

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	either maintained or removed. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the second floor dining room. Findings include: Based on observations with the Administrator and the Building Engineer during a tour of the facility from 2:00 p.m. to 3:50 p.m. on 12/06/22, the west door in the corridor door set to the second floor dining room was propped in the fully open position with a portable hand sanitizer stand. Based on interview at the time of the observations, the Director of Maintenance agreed the west door in the door set was propped open and would not fully self close and latch into the door frame. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference. 3.1-19(b)		affected by this practice. The facility's Director of Plant Operations has contracted with an approved vendor to inspect and supply the necessary self-closing/latching equipment for the second-floor dining room doors that were observed during the survey. Additionally, the portable sanitizer stand in front of the door has been removed and education will be provided to staff regarding door safety and proper usage. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** This alleged deficient practice has the potential to affect over 10 residents, staff, and visitors in the vicinity of the 2nd Floor dining room. To ensure that the identified doors self-close and latch unobstructed, the facility has contracted with an approved vendor to inspect and supply the necessary self-closing/latching equipment. Additionally, in-service training/education will be provided to staff regarding door safety and proper usage and a door safety audit will be conducted by the Director of Plant Operations or designee (see below for additional details). **What measures will be put into place or what systemic**	

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			changes will be made to ensure that the deficient practice does not recur? Contracted vendor will complete initial door inspection of the identified door set and install the required equipment needed for self-closing/latching. Specific in-service training/education will be provided to staff regarding door safety and proper usage and a door safety audit will be conducted by the Plant Director or designee to ensure that doors are functioning and unobstructed. See below for audit details. **How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The facility Director of Plant Operations or designee will oversee the vendor inspection/installation process and maintain documentation of equipment installation. A door safety audit will be conducted by the Plant Director or designee to ensure that doors are correctly functioning and unobstructed. This will occur weekly for 8 weeks, then bi-weekly for 8 weeks, then monthly for a total duration of 12 months. The results of the audits will be shared with the facility's Quality Assurance Performance Improvement Committee for	

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			additional recommendations as necessary. **Compliance Date: February 1, 2023**	
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. 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			

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	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 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 1 of 3 second floor exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC Section 19.2.2.2.4. Door-locking	K 0222	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to be affected by this practice. Immediately following the inspection, a laminated posting	02/01/2023

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	arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 10 residents, staff and visitors if needing to exit the facility using the stairwell exit on the second floor by Room 227. Findings include: Based on observations with the Administrator and the Building Engineer during a tour of the facility from 2:00 p.m. to 3:50 p.m. on 12/06/22, the stairwell exit door on the second floor by Room 227 was marked as a facility exit with an exit sign and could be opened by entering a code into a keypad at the door. However, the code was not posted at the exit door. Based on interview at the time of the observations, the Administrator stated residents who have a clinical diagnosis to be in a secure wing are housed in a secure wing on the first floor but not all residents in the smoke compartment with the second floor exit door by Room 227 have a clinical diagnosis to be in a secure wing and agreed the keypad code to release the exit door to open was not posted at the keypad. This finding was reviewed with the Administrator and the Building Engineer during the exit conference. 3.1-19(b)		was added to the keypad that lists the code for exiting the area. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** This alleged deficient practice could affect over 10 residents, staff and visitors if needing to exit the facility using the stairwell exit on the second floor by Room 227. Immediately following the inspection, a laminated posting was added to the keypad that lists the code for exiting the area. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Facility management will maintain egress doors that are compliant with federal, state, and local laws by implementing the following systemic changes. Education/in-service training will be provided to facility staff highlighting the requirements for Egress Doors. Additionally, an audit of all egress doors on the second floor will be completed by Plant Director or designee to ensure compliance (see below for details). **How will the corrective action be monitored to ensure the**	

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			deficient practice will not recur, i.e. what quality assurance program will be put into place? In-service training regarding the requirements for egress doors will be provided to facility staff. An audit of all egress doors on the second floor will be completed to ensure compliance. This audit will occur weekly for 8 weeks, then bi-weekly for 8 weeks, then monthly for a total duration of 12 months. The results of the audits will be shared with the facility's Quality Assurance Performance Improvement Committee for additional recommendations as necessary. **Compliance Date: February 1, 2023**	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 1 of 1 therapy rooms was separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment	K 0361	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to be	02/01/2023

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	rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect over 5 residents, staff and visitors in the vicinity of the basement Therapy Room. Findings include: Based on observations with the Administrator and the Building Engineer during a tour of the facility from 1:00 p.m. to 1:50 p.m. on 12/07/22, two separate corridor door sets serve as entrances to the basement Therapy Room. Each door in the two separate entrance door sets was self closing or automatic closing but each door was propped in the fully open position with a wedge placed under the door. Based on interview at the time of the observations, the Administrator stated comprehensive care residents have customary access to the basement Therapy Room and agreed the two separate entrance door sets were propped in the fully open position with a wedge placed under the door which did not ensure the Therapy Room was separated from the corridor by a partition capable of resisting the passage of smoke. This finding was reviewed with the Administrator and the Building Engineer during the exit conference. 3.1-19(b)		affected by this practice. Immediately following the Life Safety inspection, the wedge doorstops were removed from under both sets of Therapy Gym doors. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** This alleged deficient practice could affect over 5 residents, staff, and visitors in the vicinity of the basement Therapy Gym. Corrective action – the wedge doorstops were immediately removed from under both sets of doors listed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Facility management will maintain a Life Safety procedure that complies with Federal, State, and local laws. Education/in-service training will be provided to facility staff highlighting the requirements for areas that open to corridors and door safety. Additionally, an audit of all doors on the second floor will be completed by Plant Director or designee to ensure compliance (see below for details).	

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			How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? In-service training regarding the requirements for areas that open to corridors and door safety will be provided to facility staff. An audit of all doors in the basement will be completed to ensure compliance. This audit will occur weekly for 8 weeks, then bi-weekly for 8 weeks, then monthly for a total duration of 12 months. The results of the audits will be shared with the facility's Quality Assurance Performance Improvement Committee for additional recommendations as necessary. **Compliance Date: February 1, 2023**	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1)			

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	Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure 3 of 4 smoke barrier walls on the second floor were protected to maintain the fire resistance of the smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect over 20 residents, staff and visitors on the second floor. Findings include: Based on observations with the Administrator and the Building Engineer during a tour of the facility from 2:00 p.m. to 3:50 p.m. on 12/06/22, the following was noted: a. several holes were noted in the smoke barrier wall above the suspended ceiling above the corridor door set by Room 201 which were not firestopped. b. a one inch in diameter hole for the passage of one electrical conduit was noted in the smoke barrier wall above the suspended ceiling above the corridor door set by Room 215. c. the annular space surrounding two separate four inch in diameter conduits which penetrated the smoke barrier wall above the suspended ceiling above the corridor door set by Room 228 were not firestopped. In addition, a one inch in diameter hole for the passage of an electrical conduit was also noted in the smoke barrier wall. Based on interview at the time of the observations, the Building Engineer agreed the aforementioned openings in the second floor smoke barrier walls were not firestopped to maintain the fire resistance of the smoke barrier. This finding was reviewed with the Administrator	K 0372	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** No specific resident was found to be affected by this practice. Following the inspection, the holes noted in the smoke barrier walls above the suspended ceilings above the corridor door sets by Rooms 201, 215, and 228 were firestopped with an approved commercial firestop material to maintain the fire resistance of the smoke barriers in compliance with Life Safety code. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** The alleged deficient practice has the potential to affect over 20 residents, visitors, and staff on the second floor. The holes noted in the smoke barrier walls above the suspended ceilings above the corridor door sets by Rooms 201, 215, and 228 were firestopped to maintain the fire resistance of the smoke barriers in compliance with Life Safety code. **What measures will be put into place or what systemic changes will be made to**	02/01/2023

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	and the Building Engineer during the exit conference. 3.1-19(b)		**ensure that the deficient practice does not recur?** The following systemic changes will be implemented to ensure that the alleged deficient practice does not recur. Facility management will maintain a Life Safety procedure that complies with Federal, State, and local laws. Education/in-service training will be provided to facility staff highlighting the requirements for Subdivision of Building Spaces and Smoke Barriers. Additionally, an audit of all door set smoke barriers will be completed by Plant Director or designee to ensure compliance (see below for details). **How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** An audit of all door set smoke barriers will be completed by Plant Director or designee to ensure compliance. This audit will occur weekly for 8 weeks, then bi-weekly for 8 weeks, then monthly for a total duration of 12 months. The results of the audits will be shared with the facility's Quality Assurance Performance Improvement Committee for additional recommendations as necessary.	

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			Compliance Date: February 1, 2023	
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, observation and interview; the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance within the most recent four year period 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 installation. The test and inspection frequency shall be every 4 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. Section 19.4.3 states full unobstructed access to the fire damper shall be verified and corrected as required. This deficient practice could affect all	K 0521	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to be affected by this practice. Immediately following the inspection, the facility's Director of Plant Operations contracted with an approved vendor to complete the fire damper maintenance and inspection in accordance with NFPA 80 – Standard for Fire Doors and Other Opening Protectives. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** This alleged deficient practice has the potential to affect all residents, staff, and visitors. Facility has contracted with approved vendor to complete required maintenance and inspection of all Fire Dampers within the facility.	02/01/2023

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	residents, staff and visitors. Findings include: Based on review of the fire damper inspection contractor's "Invoice" documentation dated 01/18/22 with the Administrator and the Building Engineer during record review from 9:35 a.m. to 2:00 p.m. on 12/06/22, documentation of fire damper inspections conducted within the most recent four year period was not available for review. In addition, the 01/18/22 fire damper inspection documentation was also not itemized by fire damper location. Based on observations with the Administrator and the Building Engineer during a tour of the facility from 1:00 p.m. to 1:50 p.m. on 12/07/22, two fire dampers were noted in the wall of the boiler room inside the basement electrical room. Each fire damper had an affixed sticker stating "Inspected 01/17/18". Based on interview at the time of record review and of the observations, the Building Engineer stated he thought the fire damper maintenance schedule was every five years and agreed documentation of fire damper inspections conducted within the most recent four year period was not available for review. This finding was reviewed with the Administrator and the Building Engineer during the exit conference. 3.1-19(b)		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Contracted vendor will complete initial inspections/maintenance to verify that all facility fire dampers are in compliance with NFPA regulations – all fire dampers are scheduled for immediate inspection. Additionally, Facility Plant Operations personnel will receive in-service education/training on proper maintenance, inspection, and documentation of Fire Dampers. **How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The facility Director of Plant Operations or designee will oversee the inspection process and maintain compliant documentation of each inspection. The results of the inspections of the fire dampers will be shared with the facility's Quality Assurance Performance Improvement Committee for additional recommendations as necessary. **Compliance Date: February 1, 2023**	

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K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to			

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	avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 1 of 2 indoor oxygen storage areas was in accordance with NFPA 99 Health Care Facilities Code. NFPA 99, 2012 Edition, Section 11.3.1 states storage for nonflammable gases equal to or greater than 3000 cubic feet shall comply with 5.1.3.3.2 and 5.1.3.3.3. Section 5.1.3.3.2 states, if indoors, storage locations of positive-pressure gases shall be constructed and use interior finishes of noncombustible or limited combustible materials such that all walls, floor, ceilings, and doors are of minimum 1-hour fire resistant rating. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room on the second floor near the stairwell door by Room 227. Findings include: Based on observations with the Administrator and the Building Engineer during a tour of the facility from 2:00 p.m. to 3:50 p.m. on 12/06/22, the entry door to the oxygen storage and transfilling room on the second floor near the stairwell door by Room 227 was not self closing or automatic closing. A 90-minute fire resistance rating label was affixed to the hinge side of the door. Three liquid oxygen containers and nine 'E' type oxygen cylinders were observed stored in the room. Based on interview at the time of the observations, the Administrator and the Building Engineer agreed the entry door to the second floor oxygen storage and transfilling room was not self closing or automatic closing which did not ensure the room was constructed of a minimum	K 0923	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** No specific resident was found to be affected by this practice. Immediately following the inspection, the entry door to the oxygen storage and transfilling room on the second floor near the stairwell door by Room 227 was equipped with self-closing hardware – compliant with NFPA 101 requirements. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** The alleged deficient practice has the potential to affect over 10 residents, staff, and visitors in the vicinity of the oxygen storage and transfilling room on the second floor near the stairwell door by Room 227. The referenced door has been equipped with self-closing hardware – compliant with NFPA 101 requirements. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	02/01/2023

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	1-hour fire resistant rating. This finding was reviewed with the Administrator and the Building Engineer during the exit conference. 3.1-19(b)		**practice does not recur?** In-service education highlighting the requirements for gas equipment – cylinder and container storage – NFPA 101 will be provided to staff. Additionally, an audit will be completed for all oxygen storage and transfilling rooms to ensure compliance (see below for additional details). **How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Corrective actions will be monitored as follows. An audit of all oxygen storage and transfilling rooms will be completed by Plant Director or designee to ensure compliance. This audit will occur weekly for 8 weeks, then bi-weekly for 8 weeks, then monthly for a total duration of 12 months. The results of the audits will be shared with the facility's Quality Assurance Performance Improvement Committee for additional recommendations as necessary. **Compliance Date: February 1, 2023**	