STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265690	A. BUILDING **01** B. WING _____	**10/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR RETIREMENT & NURSING CENTER	**3170 HIGHWAY 61 NORTH HANNIBAL, MO 63401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Deficiencies were cited as a result of the emergency preparedness investigation.	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (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 all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.	E 004		

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

Administrator 11/10/23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 004	Continued From page 1 * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to review and update the emergency preparedness (EP) plan annually. The facility census was 52. Record review on 10/17/23 at 3:30 P.M., of the facility's EP manual dated 3/18/20, showed no documentation the plan had been reviewed or updated annually. During an interview on 10/18/23 at 11:00 A.M., the administrator said the following: -The EP manual was to be reviewed or updated annually, and when any changes were made; -The facility's EP manual had not been reviewed/updated since 3/11/21. (Record review showed no evidence of this review date); -He was responsible for monitoring, reviewing, and updating the EP.	E 004		
K 000	INITIAL COMMENTS 42 CFR 483.90(a) The facility does not meet the applicable provisions of the 2012 edition of the Life Safety	K 000		

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K 000	Continued From page 2 Code of the National Fire Protection Association and related reference documents.	K 000		
K 311 SS=E	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the barrier between floors with a fire resistance rating of at least one hour by not repairing openings in the ceiling. This deficient practice had the potential to affect 31 residents in five of seven smoke compartments and any residents, staff, and visitors who frequented the resident sitting area located near the nurses' station, the dining room, the kitchen, and the staff office area. The building capacity was 64 and the census was 52. 1. Observation on 10/17/23 between 9:20 A.M. and 6:30 P.M., during the Life Safety Code tour of the facility, showed the following: -In an unlabeled room located next to the nurses' station and clean utility room, a 0.5 inch unsealed hole in the ceiling, two white wires penetrated the ceiling through a 1 inch unsealed hole, and two	K 311		

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K 311	Continued From page 3 gray wires penetrated the ceiling through a 1 inch unsealed hole; -In the 100 hall shower room, an unsealed 0.5 inch gap in the ceiling next to a ceiling vent; -In the solarium, located at the end of the 100 hall, a 0.25 inch unsealed hole in the ceiling; -On the 300 hall, a 2 foot by 2 foot ceiling tile and a 4 inch by 2 foot ceiling tile were missing; -In the mechanical room, located near the 300 hall, four black cables penetrated the ceiling through a 1 inch unsealed hole, metal conduit penetrated the ceiling through a 1 inch unsealed hole, a pipe hanger penetrated the ceiling through a 1 inch by 2 inch rectangular unsealed hole, and a pipe hanger penetrated the ceiling through a 1 inch by 2 inch rectangular hole partially covered by duct tape; -In the dining room, a 2 foot by 2 foot ceiling tile was missing above the ice machine; -In the kitchen, a 2 foot by 2 foot ceiling vent hung down on one side and created an approximate 3 inch gap from the ceiling; -In the storage room, located behind the double doors in the dining room and next to the kitchen, a 1 inch unsealed hole in the ceiling. -In the Director of Nursing's office, a 0.75 inch unsealed hole in the ceiling; -In the Certified Nurse Aide Trainer's office, a metal conduit penetrated the ceiling through a 0.5 inch unsealed hole; -In the accountant's office, two gray cables penetrated the ceiling through a 0.5 inch unsealed hole; -In the staff copy/work room, three gray cables and two blue cables penetrated the ceiling through a 1 inch unsealed hole, and a 1.5 inch unsealed hole in the ceiling; -In the Administrator's office, a 2 foot by 3 foot ceiling tile bowed down in the center creating a 2	K 311		

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K 311	Continued From page 4 inch by 1.5 foot gap from the ceiling, and several black, white, and gray cords penetrated the ceiling through a 2 inch by 2 foot gap and a 2 inch by 6 inch gap. During interviews on 10/17/23 at 10:09 A.M., 11:19 A.M. and 2:14 P.M. and on 10/18/23 at 11:14 A.M., the Maintenance Supervisor said the following: -Workers installing a new call light system removed the two ceiling tiles on the 300 hall; -He was unsure when the workers would return to continue work on the call light system but anticipated installation of the new system to be complete by December; -He removed the ceiling tile in the dining room the prior week when the roof was patched and he needed to replace the ceiling tile. -He expected ceiling penetrations to be sealed with fire-rated caulk; -He and other maintenance staff conducted weekly walk-throughs and daily observations to monitor for unsealed ceiling penetrations; -He was unaware ceiling penetrations needed to be sealed, such as with temporary fire-rated material, when active work was not being conducted on an area. 2. Review of the 2012 edition of the NFPA 101, Section 8.3.5.1* Firestop Systems and Devices Required showed penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor/ceiling assembly constructed as a fire barrier shall be protected by a Firestop system or device.	K 311		

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K 311	Continued From page 5 Review of the 2012 edition of the NFPA 101, Section 8.3.5.1.3 showed Firestop systems and devices shall have a minimum 1-hour rating, but not less than the required fire resistance rating of the barrier penetrated.	K 311		
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 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, 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	K 363		

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K 363	Continued From page 6 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. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain corridor doors to resist the passage of smoke. This deficient practice had the potential to affect all 52 residents in five of seven smoke compartments and any residents, staff, or visitors who frequented the therapy room, staff offices, clean utility, and soiled linen rooms. The facility capacity was 64 and the census was 52. 1. Observation on 10/17/23 between 9:20 A.M. and 6:30 P.M., during the Life Safety code tour of the facility, showed the following: -In room 112, the corridor door had a 0.5 inch gap around the top and side of the door. Light was visible through the gap; -In room 102, the corridor door had a 0.25 inch gap around the top and side of the door. Light was visible through the gap; -In room 201, the corridor door had a 0.5 inch gap around the top and side of the door. Light was visible through the gap; -In room 301, the corridor door had a 0.5 inch gap around the top and side of the door. Light was visible through the gap; -In room 302, the corridor door had a 0.5 inch gap around the top and side of the door. Light was visible through the gap; -In room 304, the corridor door had a 0.5 inch gap around the top and side of the door. Light was	K 363		

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K 363	Continued From page 7 visible through the gap; -In room 305, the corridor door had a 0.5 inch gap around the top and side of the door. Light was visible through the gap; -In room 309, the corridor door had a 0.5 inch gap around the top and side of the door. Light was visible through the gap; -In room 311, the corridor door had a 0.5 inch gap around the top and side of the door. Light was visible through the gap; -In room 315, the corridor door had a 0.5 inch gap around the top and side of the door. Light was visible through the gap; -In the Certified Nursing Assistant Trainer's office, the corridor door had a pencil-sized unsealed hole located above the door knob and half of a pencil-sized unsealed hole located below the door knob; -In the clean utility room, the corridor door had four unsealed pencil-sized holes on the interior side of the door and five unsealed pencil-sized holes on the exterior side of the door; -In the therapy room, the corridor door had two pencil-sized holes at the top of the door by the closing mechanism. During interviews on 10/17/23 at 10:25 A.M., and 10/18/23 at 11:14 A.M., the Maintenance Supervisor said the following: -He was aware of the holes by the door knob on the Certified Nursing Assistant Trainer's door because about a month ago he/she changed out door knobs on the door; -He did not routinely check the corridor doors for gaps or holes; -Corridor doors should not contain gaps or holes. 2. Review of NFPA 101, 2012 Edition, Section 19.3.6.3, showed the following:	K 363		

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K 363	Continued From page 8 -19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: (1) 1-3/4 inch thick, solid-bonded core wood (2) Material that resists fire for a minimum of 20 minutes -19.3.6.3.2 The requirements of 19.3.6.3.1 shall not apply where otherwise permitted by either of the following: (1) Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials shall not be required to comply with 19.3.6.3.1. (2) In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.7, the door construction materials requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. - 19.3.6.3.5* Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction, and the following requirements also shall apply: (1) The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. (2) Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.7. - A.19.3.6.3.1 Gasketing of doors should not be necessary to achieve resistance to the passage of smoke if the door is relatively tight-fitting.	K 363		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie	K 372		

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K 372	Continued From page 9 CFR(s): NFPA 101 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) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barriers to ensure they were complete from outside wall to outside wall and from floor to roof deck. This deficient practice had the potential to affect all 52 residents in six of seven smoke compartments, including any residents, staff, or visitors who frequented the nurses' station, sitting area, activity room, and physical therapy room. The facility capacity was 64 and the census was 52. 1. Observation on 10/17/23 between 9:20 A.M. and 6:30 P.M., during the Life Safety Code tour of the facility, showed the following: -In the smoke barrier wall located at the nurses' station and the dining room (south side), a 0.5 inch by 2 inch gap in the wall around a 2 inch metal pipe, and a 0.25 inch by 2 unsealed gap in the wall around a 2 inch insulated pipe; -In the smoke barrier wall located on the 100 hall (east and west sides), approximately 15 yellow	K 372		

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K 372	Continued From page 10 wires penetrated the wall through an unsealed 3 inch gray pipe; -In the smoke barrier wall located on the 200 hall (south side), a 4 inch metal pipe penetrated the wall through an unsealed hole, and a 2 inch by 2 inch unsealed hole in the nearby drywall and joint compound; -In the smoke barrier wall located on the 200 hall (north side), approximately 15 yellow wires penetrated the wall through an unsealed 2 inch gray pipe. A 1 inch metal conduit pipe, a black wire, and a gray wire penetrated the wall through an unsealed 2 inch hole. A 0.5 inch by 3 inch unsealed gap above a 4 inch metal pipe that penetrated the wall; -In the smoke barrier wall located on the 300 hall (west side), a 2 inch metal flexible conduit penetrated the wall and was sealed with orange-colored spray foam. There was a 0.5 inch unsealed gap in the wall around the pipe; -In the smoke barrier wall located on the 300 hall (east side), a 3 inch unsealed pipe passed through an unsealed hole, and 2 inch by 2 inch unsealed hole in the wall; -In the smoke barrier wall located by the physical therapy room (west side), two 1 inch unsealed holes in the wall. A black, a white, and a gray wire passed through one of the holes; -In the smoke barrier wall located by the physical therapy room (east side), a 0.5 inch by 0.5 inch unsealed gap in the wall above an 8 inch flexible ductwork that penetrated the wall; -In the smoke barrier wall located by the activity room (east side), a 0.5 inch by 4 inch unsealed gap in the wall above an 8 inch flexible ductwork that penetrated the wall. A blue wire penetrated the wall through an unsealed 3 inch round hole; -In the smoke barrier wall located by the activity room (west and south sides), a 2 inch by 8 inch	K 372		

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K 372	Continued From page 11 unsealed gap in the wall around an 8 inch flexible ductwork that penetrated the wall; -In the smoke barrier wall located by the activity room (north side), a 3 inch by 8 inch unsealed gap in the wall around an 8 inch flexible ductwork that penetrated the wall. A 1 inch flexible conduit penetrated the wall through a 2 inch by 2 inch square unsealed hole. During an interview on 10/18/23 at 11:14 A.M. the Maintenance Supervisor said he expected penetrations in the facility's smoke barrier walls to be sealed with fire-rated caulk. 2. Review of 2012 NFPA 101, 8.5.2.1 showed smoke barriers shall be continuous from an outside wall to an outside wall, from a floor to a floor, or a smoke barrier to a smoke barrier, or by use of a combination thereof. Review of 2012 NFPA 101, 8.5.2.2 showed smoke barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.	K 372		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.	K 712		

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K 712	Continued From page 12 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to conduct fire drills at unpredictable times. This deficient practice had the potential to affect all residents in seven of seven smoke compartments. The facility capacity was 64 and the census was 52. 1. Record review on 10/17/23 of the facility fire drills conducted on the 6:00 A.M. to 2:00 P.M. (first shift) during the previous 12 months, showed the following: -On 12/20/22 at 10:00 A.M.; -On 03/13/23 at 2:00 P.M.; -On 06/16/23 at 10:00 A.M.; -On 09/13/23 at 10:30 A.M. -Three of four fire drills were conducted within 30 minutes of each other on the same shift, making them predictable. During an interview on 10/18/23 at 11:14 A.M., the Maintenance Supervisor said the following: -He tried to schedule fire drills at least two hours apart; -He was unaware the drills conducted on the first shift (6:00 A.M. to 2:00 P.M.) during the previous 12 months were not varied, with drills conducted at 10:00 A.M. (12/20/22), 10:00 A.M. (06/16/23), and 10:30 A.M. (09/13/23). 2. Review of NFPA 101, 2012 Edition, section 19.7.1.6 regarding simulated conditions showed drills shall be conducted quarterly on each shift to familiarize facility personnel with the signals and emergency action required under varied conditions.	K 712		

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	265690	A. BUILDING **01** B. WING _____	**10/18/2023**

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K 712	Continued From page 13 Review of 2012 NFPA 101 appendix 19.7.1.4 showed many health care occupancies conduct fire drills without disturbing patients by choosing the location of the simulated emergency in advance and by closing the doors to patients' room or wards in the vicinity prior to initiation of the drill. The purpose of a fire drill is to test and evaluate the efficiency, knowledge, and response of institutional personnel in implementing the facility fire emergency plan. Its purpose is not to disturb or excite patients. Fire drills should be scheduled on a random basis to ensure that personnel in health care facilities are drilled not less than once in each three-month period. Drills should consider the ability to move patients to an adjacent smoke compartment. Relocation can by practiced using simulated patients or empty wheelchairs.	K 712		
K 741 SS=E	Smoking Regulations CFR(s): NFPA 101 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	K 741		

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K 741	Continued From page 14 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 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoking areas to ensure cigarettes were properly disposed in ashtrays, and failed to ensure cigarette butts and ashes were not intermixed with combustible trash. This deficient practice had the potential to affect 17 residents in one of seven smoke compartments and any residents, staff, or visitors who frequented the shared resident and staff smoking area. The facility capacity was 64 and the census was 52. 1. Observation on 10/17/23 between 9:20 A.M. and 6:30 P.M., during the exterior Life Safety Code tour of the facility, showed the following: -The shared resident and staff smoking area was located outside the facility near the solarium; -The garbage can contained cigarette butts and ashes mixed with combustible paper trash; -The red self-closing metal can (for the disposal of cigarette butts) contained a paper cigarette box intermixed with cigarette butts and ashes; -Approximately 15 burnt cigarette butts lay on the ground and were not properly disposed of in an ashtray. During an interview on 10/17/23 at 2:30 P.M., the	K 741		

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K 741	Continued From page 15 Maintenance Supervisor said maintenance staff was responsible for checking the smoking area daily. Housekeeping staff was responsible for emptying the garbage can and the red self-closing can. Staff and residents should place cigarette butts in ashtrays and not on the ground. Cigarette butts and ashes should not be mixed with paper trash. 2. Review of 2012 edition of NFPA 101 section 19.7.4 showed smoking regulations shall be adopted and shall include not less than the following provisions: -Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. -Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 741		
K 761 SS=E	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80)	K 761		

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K 761	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one-fire rated door assembly was inspected annually in accordance with NFPA 80 (Standard for Fire Doors and Other Opening Protectives), 2010 edition. The facility also failed to maintain fire doors to ensure required fire resistance. This deficient practice had the potential potential to affect occupants who frequented the areas between the solarium, beauty shop and the independent living in one of seven smoke compartments. The facility capacity was 64 and the census was 52. 1. Record review on 10/17/23 showed no documentation that an annual fire-rated door assembly inspection had been completed in the last 12 months. Observation on 10/17/23 at 10:02 A.M. showed a single fire-rated door assembly was located between the skilled nursing facility (SNF) and the attached independent living (IL) facillity. The fire door had four screw-sized unsealed holes in the upper right corner, a 0.5 inch unsealed hole in the upper right corner, a 0.25 inch unsealed hole by the latch, and a small cable that penetrated through a 0.5 inch unsealed hole. During an interview on 10/17/23 at 10:02 A.M., the Maintenance Supervisor said he was aware of some of the holes in the fire door and assumed they were from previous door hardware that was replaced. During an interview on 10/18/23 at 12:31 P.M., the Administrator said the following:	K 761		

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K 761	Continued From page 17 -An annual inspection had not been conducted on the fire door; -He was unaware of the requirement of the annual inspection for the facility's fire door; -He expected the Maintenance Supervisor to schedule required routine inspections and maintain applicable paperwork; -It was ultimately his responsbility (as the Administrator) to ensure required inspections were conducted. 2. Review of 2012 NFPA 101, Section 7.2.1.15.2 showed fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives. Review of 2012 NFPA 101, Section 8.3.3, Fire Doors and Windows, and Section 8.3.3.1 showed openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. Review of 2012 NFPA 101, Section 7.2.1.15.7 showed as a minimum, the following items shall be verified: (1) Floor space on both sides of the opening is clear of obstructions, and door leaves open fully and close freely; (2) Forces required to set door leaves in motion	K 761		

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K 761	Continued From page 18 and move to the fully open position do not exceed the requirements in 7.2.1.4.5; (3) Latching and locking devices comply with 7.2.1.5; (4) Releasing hardware devices are installed in accordance with 7.2.1.5.10.1; (5) Door leaves of paired openings are installed in accordance with 7.2.1.5.11; (6) Door closers are adjusted properly to control the closing speed of door leaves in accordance with accessibility requirements; (7) Projections of door leaves into the path of egress does not exceed the encroachment permitted by 7.2.1.4.3; (8) Powered door openings operate in accordance with 7.2.1.9; (9) Signage required by 7.2.1.4.1(3), 7.2.1.5.5, 7.2.1.6 and 7.2.1.9 is intact and legible; (10) Door openings with special locking arrangements function in accordance with 7.2.1.6; (11) Security devices that impede egress are not installed on openings, as required by 7.2.1.5.12.	K 761		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 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	K 920		

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K 920	Continued From page 19 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 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the proper use of power strips, extension cords and multi-plug adapters in accordance with NFPA 70, National Electric Code. This deficient practice had the potential to affect 14 residents in three of seven smoke compartments and any residents, staff or visitors who frequented the nurses's station, sitting area near the nurses' station, or administrative offices. The facility capacity was 64 and the census was 52. Review of the undated facility policy, Personal Inventory Policy, showed no extension cords or breaker power strips are allowed in the building unless approved by the administrator or maintenance. All power strips must be marked indicating they have been approved. 1. Observation on 10/17/23 between 9:20 A.M. and 6:30 P.M., during the Life Safety Code tour of the facility, showed the following: -In the Director of Nursing's office, a space heater was plugged into a power strip;	K 920		

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K 920	Continued From page 20 -In occupied resident room 314, a multi-plug adapter was plugged into the wall outlet; -In the accounts payable office, an electric space heater and an adding machine were plugged into an extension cord. The extension cord was plugged into a power bank that was plugged into the wall outlet; -In the accounting office, two desk lights and a calculator were plugged into an extension cord that was plugged into the wall outlet. A space heater was plugged into the wall outlet. -In the housekeeping/laundry supervisor's office, an electric paper shredder was plugged into a power strip; -In the Maintenance Supervisor's office, an extension cord was plugged into an outlet. Nothing was plugged into the cord. During an interview on 10/18/23 at 11:07 A.M., the Maintenance Supervisor said power strips could be used in the facility if they were UL listed and should not have motorized or medical equipment plugged into them. Extension cords were not allowed to be used. He was unsure if adapters could be used. 2. Review of NFPA 70 section 400.8 Uses Not Permitted showed unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception to (4): Flexible cord and cable shall be	K 920		

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K 920	Continued From page 21 permitted to be attached to building surfaces in accordance with the provisions of 368.56(B) (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code (7) Where subject to physical damage.	K 920		
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 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	K 923		

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K 923	Continued From page 22 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 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) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure oxygen was not stored within five feet of combustibles in accordance with NFPA 99. This deficient practice had the potential to affect 17 residents in one of seven smoke compartments. The facility capacity was 64 and the census was 52. 1. Observation on 10/17/23 at 9:30 A.M., of the full oxygen cylinder storage room, located on a short hallway adjacent to the 100 hall, showed the room contained approximately 50 full oxygen cylinders. Two wooden shelves, two cardboard boxes and a plastic storage bin unit with miscellaneous plastic oxygen supplies were all stored less than five feet above the stored oxygen cylinders. Observation on 10/17/23 at 9:38 AM., of the empty oxygen cylinder storage room, located next to the full oxygen cylinder storage room, showed three wooden shelves and a cardboard box were stored less than five feet above the stored cylinders. During an interview on 10/18/23 at 11:07 A.M., the Maintenance Supervisor said he was unaware combustibles could not be stored within five feet of oxygen cylinders. He was aware of the	K 923		

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K 923	Continued From page 23 combustible items in the oxygen storage rooms. 2. Review of the 2012 edition of NFPA 99, Section 11.3.2.3 showed oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) Minimum distance of 20 feet; (2) Minimum distance of 5 feet if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1/2 hour.	K 923		

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A2007	19 CSR 30-85.022(3) Noncombustible Material Between Floors All openings that could permit the passage of fire, smoke, or both, between floors shall be fire-stopped with a suitable noncombustible material. II/III This regulation is not met as evidenced by: Class II* Refer to K311 *The higher classification merited due to extent of the violation.	A2007		
A2010	19 CSR 30-85.022(6) Oxygen Storage Oxygen storage shall be in accordance with NFPA 99, 1999 edition. Facilities shall use permanent racks or fasteners to prevent accidental damage or dislocation of oxygen cylinders. Safety caps shall remain intact except where a cylinder is in actual use or where the regulator has been attached and the cylinder is ready for use. Individual oxygen cylinders in use or with an attached regulator shall be supported by cylinder collars or by stable cylinder carts. II/III This regulation is not met as evidenced by: Class II* Refer to K923 *The higher classification merited due to the extent of the violation.	A2010		
A2054	19 CSR 30-85.022(29) Smoke Section Walls/Doors Each smoke section shall be separated by one-(1-) hour fire-rated walls that are continuous from	A2054		

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A2054	Continued From page 1 outside wall-to-outside wall and from floor-to-floor or floor-to-roof deck. All doors in this wall shall be at least twenty- (20-) minute fire rated or its equivalent, self-closing, and may be held open only if the door closes automatically upon activation of the fire alarm system. II This regulation is not met as evidenced by: Class II Refer to K372	A2054		
A2057	19 CSR 30-85.022(32) Ashtrays Noncombustibles/Safe/Disposal Designated smoking areas shall have ashtrays of noncombustible material and of safe design. The contents of ashtrays shall be disposed of properly in receptacles made of noncombustible material. II/III This regulation is not met as evidenced by: Class II* Refer to K741 *The higher classification merited due to the extent of the violation.	A2057		
A3001	19 CSR 30-85.032(2) Substantially Constructed/Maintained The building shall be substantially constructed and shall be maintained in good repair. New facilities shall comply with the requirements in accordance with the provisions found in 19 CSR 30-85.012. Existing licensed facilities shall meet and maintain the facility's physical plant in accordance with the construction standards in	A3001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04673	A. BUILDING: 01 B. WING _____	10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR RETIREMENT & NURSING CI	3170 HIGHWAY 61 NORTH HANNIBAL, MO 63401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A3001	Continued From page 2 effect at the time of initial licensing, unless there is a specific rule governing the subject cited in this section or in 19 CSR 30-85.022, except that those facilities licensed between 1957 and 1965 shall not increase the capacity of any room or the total capacity of the facility without meeting new construction requirements. Existing licensed facilities with plans approved after April 8, 1972 and prior to January 1, 1999, shall comply as Existing Health Care Occupancies with NFPA 101, 2000 edition. Facilities whose physical plant requirement plans are approved on or after January 1, 1999, shall comply as New Health Care Occupancies with NFPA 101, 2000 edition. II/III This regulation is not met as evidenced by: Class II* Refer to K363 *The higher classification merited due to the extent of the violation.	A3001		
A3027	19 CSR 30-85.032(28) Heating System-No Portable The heating of the building shall be restricted to steam, hot water, permanently installed electric heating devices or warm air systems employing either central heating plants with installation so as to safeguard the inherent fire hazard or outside wall heaters with approved installation. Portable heater use is prohibited. Facilities shall provide adequate guards to safeguard residents where potential burn hazards exist. I/II This regulation is not met as evidenced by: Class II	A3027		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04673	A. BUILDING: 01 B. WING _____	10/18/2023

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A3027	Continued From page 3 Based on observation and interview, the facility failed to prohibit portable space heater use in the facility. The census was 52. Observations on 10/17/23 between 9:20 A.M. and 6:30 P.M., during the Life Safety Code tour of the facility, showed the following: -In the director of nursing office, a portable space heater was located under the desk and was plugged into power; -In the accounts payable office, a portable space heater was plugged into power; -In the accounting office, a portable space heater was plugged into power. During an interview on 10/18/23 at 11:14 A.M., the Maintenance Supervisor said portable space heaters were not allowed in resident rooms. He was unaware portable space heaters were not allowed in staff offices.	A3027		
A3030	19 CSR 30-85.032(31)(A) Electrical Wiring & Equipment Maintained Electrical Wiring Requirements. (A) Electrical wiring and equipment shall be installed and maintained in accordance with the NFPA 70, 1999 edition. Facilities that were complying prior to the effective date of this rule with prior editions of the NFPA 70 referenced in this rule shall be permitted to continue to comply with the earlier editions, as long as there is not an imminent danger to the health, safety, or welfare of any resident or a substantial probability that death or serious physical harm would result as determined by the department. II/III This regulation is not met as evidenced by: Class II*	A3030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04673	A. BUILDING: 01 B. WING _____	10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR RETIREMENT & NURSING CI	3170 HIGHWAY 61 NORTH HANNIBAL, MO 63401

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A3030	Continued From page 4 Refer to K920 *The higher classification merited due to the extent of the violation.	A3030		
A3031	19 CSR 30-85.032(31)(B) Electrical System-Certification Every 2 Years Electrical Wiring Requirements. (B) Every two (2) years, a qualified electrician will be required to certify in writing that the electrical system is being maintained and operated in accordance with the standards outlined by the NFPA 70, 1999 edition or the earlier NFPA 70 edition with which the facility was complying prior to the effective date of this rule. II/III This regulation is not met as evidenced by: Class II* Based on observation, interview, and record review, the facility failed to ensure an electrical wiring inspection was conducted every two years. The census was 52. Record review on 10/17/23 showed the most recent electrical wiring certification inspection was conducted on 1/11/21. The facility was unable to provide any documentation to show an inspection was conducted in the last two years. During an interview on 10/18/23 at 11:07 A.M., the Maintenance Supervisor said maintenance staff was responsible for ensuring the required electrical wiring inspection was performed at the required intervals. He thought an electrician had been at the facility over the summer in 2023. *Higher classification due to the extent of the	A3031		

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A3031	Continued From page 5 violation and when combined with other deficiencies.	A3031		

PLAN OF CORRECTION

Provider/Supplier Name:	Luther Manor Retirement & Nursing Center
Street Address, City, Zip:	3170 Highway 61, Hannibal, Missouri, 63401
Date of Survey:	10/18/2023

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
E004	Emergency Preparedness Plan has been reviewed and updated by Administrator per requirements at 42CFR§483.73. A signature page has been added to both the paper and electronic copies of the Emergency Preparedness Plan to demonstrate date of most recent review. The QAPI dashboard shall be updated to include an annual assessment of the Emergency Preparedness Plan.	12/01/2023
K311	All vertical openings and penetrations through ceilings will be repaired by Maintenance Staff to correct deficient practice. Ceiling penetrations shall be added to weekly walkthrough to be performed by Maintenance Supervisor. The Maintenance Supervisor shall report compliance monthly to Administrator to populate QAPI dashboard.	12/01/2023
K363	All holes and penetrations in corridor doors will be repaired and filled with wood filler on both sides by maintenance staff to correct deficient practice. Weatherstripping will be utilized to fill gaps around corridor doors. Door penetrations and gaps will be added to weekly walkthrough to be checked by Maintenance Supervisor. Maintenance Supervisor shall report compliance monthly to Administrator to populate QAPI dashboard.	12/01/2023
K372	All smoke barrier/fire wall penetrations will be repaired and corrected with red fire rated caulk by Maintenance staff to correct deficient practice. Larger openings will be repaired with drywall and compound by maintenance staff to correct deficient practice. Penetrations for smoke barrier and fire wall shall be added to weekly walkthrough to be performed by Maintenance Supervisor. Maintenance Supervisor shall report compliance monthly to Administrator to populate QAPI dashboard.	12/01/2023
K712	Fire Drills will be carefully scheduled by the Maintenance Supervisor to ensure spacing of two hours between drills for the entire calendar year to correct deficient practice. The Maintenance Supervisor shall report compliance monthly to Administrator to populate QAPI dashboard.	12/01/2023
K741	Smoking area will be checked on a weekly basis by Maintenance staff and added to the weekly walk-through to correct deficient practice. The Maintenance Supervisor shall report compliance monthly to Administrator to populate QAPI dashboard.	12/01/2023

K761	All Fire Doors will be inspected by Hannibal Overhead Doors to correct deficient practice. All Fire Doors will be maintained, inspected, and tested once every twelve months by Hannibal Overhead Doors to correct deficient practice. Maintenance Supervisor shall report compliance annually to Administrator to populate QAPI dashboard.	12/01/2023
K920	All power strips in use within the facility will be checked for appropriate items plugged into it, appropriate UL listing, and marked and recorded on weekly walkthrough by Maintenance Supervisor to correct deficient practice. All extension cords will be removed except those in temporary use on weekly walkthrough by Maintenance Supervisor. All power strips must be checked and approved by Maintenance Supervisor or Maintenance staff prior to placement to correct deficient practice. All multi-plugs witnessed within the facility during walkthrough shall be removed immediately by Maintenance Supervisor. Maintenance Supervisor shall report compliance monthly to Administrator to populate QAPI dashboard.	12/01/2023
K923	All wooden shelves and other combustibles have been removed from full and empty oxygen storage rooms by Maintenance Supervisor to correct deficient practice. Signs have been posted on outside of both doors stating No Combustibles allowed in these rooms. Oxygen storage rooms shall be added to the weekly walkthrough checklist to be performed by Maintenance Personnel. The Maintenance Supervisor shall report compliance monthly to the Administrator to populate the QAPI dashboard.	12/01/2023
A2007	Refer to K311	12/01/2023
A2010	Refer to K923	12/01/2023
A2054	Refer to K372	12/01/2023
A2057	Refer to K741	12/01/2023
A3001	Refer to K363	12/01/2023
A3027	Portable space heaters have been removed from the building, and specifically the Director of Nursing office, the Accounts Payable office, and the accountant office by maintenance staff. Space heater removal will be added to the weekly walkthrough checklist to be performed weekly by the Maintenance Supervisor. The walkthrough checklist shall be provided monthly to the Administrator for population of the QAPI dashboard.	12/01/2023
A3030	Refer to K920	12/01/2023
A3031	Maintenance Supervisor shall have the facility inspected by an electrician immediately and maintain certificate to correct deficient practice. An electrician shall be contracted every two years to provide inspection certificate to correct deficient practice. The Maintenance Supervisor shall report compliance to Administrator every two years and provide certification to populate the QAPI dashboard.	12/01/2023

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.