STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265719	A. BUILDING 01 B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBERWOOD ESTATES NURSING AND REHABILITATION	5303 BERMUDA DRIVE NORMANDY, MO 63121

(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

UNH | 5/10/24

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 interview and record review, the facility failed to update their Emergency Operations Plan (EOP) at least annually. This deficiency had the potential to affect all occupants of the building. The facility has a capacity of 115 and had a census of 87 residents at the time of the survey. Review of the EOP provided by the facility on 4/17/24, showed the following: -The name of the facility was not current on the Facility Profile; -The list of Emergency Contacts included a former Administrator, former Director of Nursing (DON) and former Maintenance Director; -The list of Water Management Team members included a former Administrator and former Maintenance Director; -The list of COVID Response Committee members included a former Administrator, former DON and former Maintenance Director; -The Hazard Vulnerability Assessment was completed in February 2021; -Three facilities were listed as evacuation sites for residents; -One facility's name was not current;	E 004		

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E 004	Continued From page 2 -One of the listed facilities closed on 5/22/23. -The plan was signed by a former Administrator on 5/24/22. During an interview on 4/17/24 at 11:15 A.M., the Administrator said it was the Administrator's role to ensure the EOP was kept updated. He had only been the Administrator of the facility for two weeks, and there had been several management changes in recent months at the facility. He knew the plan needed to be updated and planned to do it.	E 004		
K 000	INITIAL COMMENTS 42 CFR 483.90 (a) The facility does not meet the applicable provisions of the 2012 existing edition of the Life Safety Code of the National Fire Protection Association (NFPA) and related reference documents.	K 000		
K 161 SS=E	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories	K 161		

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K 161	Continued From page 3 sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain appropriate construction standards, with proper smoke resisting and fire resistance rated walls as required by the Life Safety Code. The facility is composed of protected wood frame construction and did not provide continuous walls that protected the studs and interstitial spaces. This deficient practice had the potential to affect all occupants in one of seven smoke compartments. This facility had a capacity of 115 and a census of 87 residents at the time of the survey. Observation on 4/16/24 at 11:30 A.M., showed	K 161		

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K 161	Continued From page 4 two cut out, missing pieces of dry wall on the left side of the 500 hall soiled utility room. One area was approximately 2 foot by 2 foot and another area was approximately 1 foot by 3 foot. The open areas in the dry wall exposed the piping and wood studs behind the wall. During an interview on 4/16/24 at 11:30 A.M., the Maintenance Director said the areas of open dry wall had been like that since he started at the facility (January 2024). He thought the areas were there in case work needed to be completed on the pipes and the opened areas allowed access to the pipes. NFPA 101 (2012) 8.4.4.1 Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a smoke partition shall be protected by a system or material that is capable of limiting the transfer of smoke.	K 161		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 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	K 222		

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K 222	Continued From page 5 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 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	K 222		

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K 222	Continued From page 6 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 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure delayed-egress exit doors were maintained in accordance with NFPA 101. This deficiency had the potential to affect all occupants in two of seven smoke compartments in an emergency. The facility has a capacity of 115 and had a census of 87 residents at the time of the survey. 1. Observation on 4/16/24 at 9:45 A.M., showed the facility staff activated the fire alarm system. The front exit door had an affixed sign that read "Push until alarm sounds. Door can be opened in 15 seconds." The door did not immediately release and could not be opened when the fire alarm activated. 2. Observation on 4/16/24 at 9:45 A.M., showed the facility staff activated the fire alarm system. The back exit door near room 500 had an affixed sign that read "Push until alarm sounds. Door can be opened in 15 seconds." When the door was pushed, it could not be opened. A heavy bag of sand or salt was placed directly in front of the exit doors. During an interview on 4/16/24 at 9:45 A.M. the Maintenance Director said the staff probably placed the sandbag in front of the door because when the wind caught the doors, it would cause the doors to alarm. A company was at the facility	K 222		

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K 222	Continued From page 7 a few weeks ago inspecting all of the delayed egress doors, but then they had to leave in the middle of the job and did not come back to finish it yet. Observation on 4/16/24 at 11:45 A.M., of the exit door near room 500 showed once the sandbag was removed from the door, the door could be opened without a code and without activating the delayed-egress sequence. Although the exit door had signs indicating it was on delayed-egress, the delayed egress function was not in place. During an interview on 4/16/24 at 11:45 A.M., the Maintenance Director said the keypad/delayed egress system for this door had not been active since he had been there (January 2024). 3. During an interview on 4/17/24 at 11:00 A.M., the Regional Maintenance Director said staff should check the delayed-egress doors monthly with the fire drills. NFPA 101 (2012) 7.1.10.1: Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. NFPA 101 (2012) 7.2.1.6.1.1 Delayed-Egress Locking Mechanisms (1) The door leaves shall unlock in the direction of egress upon actuation of one of the following: (a) Approved, supervised automatic sprinkler system in accordance with Section 9.7 (b) Not more than one heat detector of an approved, supervised automatic fire detection system in	K 222		

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K 222	Continued From page 8 accordance with Section 9.6 (c) Not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6 (2) The door leaves shall unlock in the direction of egress upon loss of power controlling the lock or locking mechanism	K 222		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure emergency lighting was tested monthly and maintained in accordance with NFPA code. This deficiency had the potential to affect all building occupants in three of seven smoke compartments in the event of an emergency. The facility has a capacity of 115 and had a census of 87 residents at the time of the survey. 1. Observations during the Life Safety Code tour on 4/16/24 between 7:00 A.M. and 4:00 P.M., showed the battery operated emergency lights did not operate when the test button was pushed, in the following areas of the building: -In the medication room at that main nurses' station; -In the main electrical/generator transfer switch	K 291		

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K 291	Continued From page 9 room; -The exterior light at the back dining room exit. 2. Review of the facility's maintenance records showed the following testing documentation for the battery-operated emergency lights: -An annual 90 minute test completed on 10/22/23; -Monthly tests completed on 1/2/24, 2/16/24 and 3/15/24; -No other documentation of monthly tests completed in 2023. During an interview on 4/17/24 at 9:15 A.M., the Maintenance Director said he could not locate any other monthly testing from 2023. During an interview on 4/17/24 at 11:10 A.M., the Regional Maintenance Director said the battery operated lighting should be tested on a monthly basis. During an interview on 4/16/24 at 3:30 P.M., the Administrator said the last two former Maintenance Directors walked off with items from the facility and they cannot locate some of the maintenance log books from when the previous Maintenance Director worked at the facility. NFPA 101 (2012) 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the	K 291		

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K 291	Continued From page 10 authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1.5 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	K 291		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons)	K 321		

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K 321	Continued From page 11 f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain hazardous areas with corridor doors equipped with self-closing devices. This deficiency had the potential to affect occupants in one of seven smoke compartments. The facility has a capacity of 115 and had a census of 87 residents at the time of the survey. Observation on 4/16/24 at 10:20 A.M. of the beauty shop showed the following: -The room was greater than 50 square feet; -Approximately 20 cardboard boxes of medical records located in the room; -The door to the corridor did not feature a self-closing device. During an interview on 4/16/24 at 10:25 A.M., the Maintenance Director said the medical records boxes had been moved up from the back and had been in their current location since he started working at the facility (January 2024).	K 321		
K 352 SS=F	Sprinkler System - Supervisory Signals CFR(s): NFPA 101 Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is	K 352		

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K 352	Continued From page 12 impaired. 9.7.2.1, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure deficiencies identified during sprinkler inspections were corrected in a timely manner. This deficiency had the potential to affect all building occupants. The facility has a capacity of 115 and had a census of 87 residents at the time of the survey. Review of the facility's maintenance records showed the following: -The annual sprinkler inspection, dated 7/31/23, listed a device deficiency of a functional/visual failure of a supervisory low air pressure switch; -A quarterly sprinkler inspection, dated 10/10/23, listed a device deficiency of a functional/visual failure of a supervisory low air pressure switch; -A quarterly sprinkler inspection, dated 1/15/24, listed a device deficiency of a functional/visual failure of a supervisory low air pressure switch; -A quarterly sprinkler inspection, dated 4/15/24, listed a device deficiency of a functional/visual failure of a supervisory low air pressure switch. During an interview on 4/17/24 at 10:50 A.M., the Regional Maintenance Director and the Administrator said they were not previously aware of the problem with the supervisory low air switch. If they had known about it earlier, the repair would have been scheduled and completed. NFPA 101 (2012) 9.7.2 Supervision. 9.7.2.1* Supervisory Signals. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for	K 352		

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(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
K 352	Continued From page 13 integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility.	K 352		
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure portable fire extinguishers were maintained in accordance with requirements of NFPA 10. These deficient practices had the potential to affect all residents in six of seven smoke compartments. The facility has a capacity of 115 and had a census of 87 residents at the time of the survey. Observation during the Life Safety Code tour on 4/16/24 between 7:00 A.M. and 4:00 P.M., showed ABC fire extinguishers, serviced in January 2024, with no monthly checks documented for February 2024 or March 2024, for the extinguishers in the following areas: -Near the telephone room; -Outside of the kitchen; -Near room 312;	K 355		

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K 355	Continued From page 14 -Near room 517; -Near the main nurses' station; -Near room 107. Review of the documentation from the fire extinguisher service company, dated 1/31/24, showed 17 ABC fire extinguishers were serviced at the facility on 1/31/24. During an interview on 4/17/24 at 10:55 A.M., the Regional Maintenance Director said the fire extinguishers should be checked monthly and documented on the fire extinguisher tag. He did not know why the monthly checks were not completed in February and March 2024. NFPA 10 (2010) 7.2 Inspections 7.2.1.2* Fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals.	K 355		
K 363 SS=E	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.	K 363		

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K 363	Continued From page 15 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 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 so there was no impediment to the closing of the doors and failed to ensure doors were maintained free from holes. This deficiency had the potential to impact the residents and staff in three of seven smoke compartments in the event of a fire. The facility has a capacity of 115 and had a census of 87 residents at the time of the survey. Observation on 4/16/24 during the Life Safety Code tour between 7:00 A.M. and 4:00 P.M., showed the following: -The door from the therapy room to the corridor,	K 363		

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K 363	Continued From page 16 held in the open position by weights on the floor; -The door from the 100 hall Day Room/office to the corridor had an approximate 0.25 inch diameter hole above the door knob and below the door knob; -The door from the 100 hall Day Room/break room to the corridor had an approximate 0.25 inch diameter hole in the door near the door knob; -The door from the conference room to the corridor had an approximate 0.25 inch diameter hole above the door knob and below the door knob; -The door from the housekeeping office to the corridor, held in the open position by a plastic container on the floor. During an interview on 4/17/24 at 9:00 A.M., the Maintenance Director said that he tested the corridor doors in March 2024. During interviews on 4/16/24 at 11:00 A.M. and on 4/17/24 at 10:55 A.M., the Regional Maintenance Director said the small holes in the doors happened when someone changed the commercial door knob to a regular door knob in some of the corridor doors. Staff should check the corridor doors on a monthly basis.	K 363		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie 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	K 372		

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K 372	Continued From page 17 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 barrier walls with the required fire resistance rating. The facility failed to ensure the functioning of one of two smoke dampers and failed to ensure a smoke barrier wall access door was self-closing. This deficiency had the potential to affect all building occupants in four of seven smoke compartments. The facility has a capacity of 115 and had a census of 87 residents at the time of the survey. 1. Observation on 4/16/24 at 9:45 A.M., showed staff activated the fire alarm. The smoke damper located in the attic space at the 100 hall smoke barrier wall did not function. During an interview on 4/16/24 at 10:00 A.M., the Regional Maintenance Director said that he did not know when the last time the dampers were checked since he and the Maintenance Director did not previously know the locations of the smoke dampers prior to today. 2. Observation on 4/16/24 at 8:30 A.M., showed a smoke barrier wall located near the 400/500 hall nurses' station. An access door was located within the wall, in order to get to the other side of the barrier wall. The door had a spring attached to it, but the door did not self-close when opened.	K 372		

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K 372	Continued From page 18 During an interview on 4/16/24 at 8:30 A.M., the Maintenance Director said it looked like the spring had been over-stretched and no longer worked to close the door as it should. NFPA 101, 2012, 8.5.2.2: 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. 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 ensure fire drills were completed on each shift, quarterly, for four of four quarters reviewed. This deficiency had the potential to affect all occupants of the facility in the event of a fire. The facility has a capacity of 115 and had a census of 87 residents at the time of the survey. Review of the facility's maintenance records showed the following fire drills: -Fire drill on 1/12/24 at 5:07 P.M., during the evening shift;	K 712		

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K 712	Continued From page 19 -Fire drill on 2/27/24 at 1:30 P.M., during the day shift; -No other documented fire drills for the first quarter of 2024; -No fire drills documented in 2023. During an interview on 4/17/24 at 9:59 A.M., the Maintenance Director said he could not locate any other fire drill documentation. During an interview on 4/17/24 at 11:20 A.M., the Regional Maintenance Director said they could not locate any other fire drill documentation. During an interview on 4/16/24 at 3:30 P.M., the Administrator said they have had two former Maintenance Directors leave with supplies, and they think the last Maintenance Director did something with the maintenance log books when he left. They were having difficulties locating all of the past paperwork.	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.	K 741		

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K 741	Continued From page 20 (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to dispose of ashtray contents in accordance with NFPA regulations and standards. This deficiency had the potential to affect all staff and residents who used the designated smoking area. The facility has a capacity of 115 and had a census of 87 residents at the time of the survey. Observation 4/16/24 at 11:05 A.M., of the courtyard smoking area near the main nurses' station, showed the following: -A metal trash can, approximately three-quarters full of plastic and paper trash, along with approximately 20 cigarette butts; -Approximately 15 cigarette butts on the sidewalk area. During an interview on 4/17/24 at 11:00 A.M., the Administrator said they had a few residents who were non-compliant with the smoking rules. Housekeeping and maintenance staff were responsible for maintaining the smoking areas.	K 741		

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K 741	Continued From page 21 NFPA 101 (2012) 19.7.4 (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.	K 741		
K 761 SS=F	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) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide documentation for the annual inspection of all doors equipped with panic hardware, doors equipped with special locking arrangements and doors located within a means of egress, in accordance with the 2012 Edition of NFPA 101 (Life Safety Code). Failure to inspect, test and maintain the doors in an egress pathway could result in equipment failure in the event of an emergency and delay evacuation. This failure has the potential to affect all facility occupants. The facility capacity was 115 and the census was 87 residents at the time of the survey.	K 761		

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K 761	Continued From page 22 Observation on 4/16/24 between 7:00 A.M. and 4:00 P.M., showed the following types of doors, located throughout the facility: -Smoke barrier doors; -Exit doors; -Doors with special locking arrangements. Review of the facility's maintenance records, showed: -Corridor doors checked in March 2024; -No documentation of other doors inspected. During an interview on 4/16/24 at 9:45 A.M. the Maintenance Director said a company was at the facility a few weeks ago inspecting all of the delayed egress doors, but then they had to leave in the middle of the job and did not come back to finish it yet. NFPA 101 (2012) 4.6.12 Maintenance, Inspection, and Testing: - 4.6.12.5 Maintenance, inspection, and testing shall be performed under the supervision of a responsible person who shall ensure that testing, inspection, and maintenance are made at specified intervals in accordance with applicable NFPA standards or as directed by the authority having jurisdiction. -7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8: (1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7; (2) Door assemblies in exit enclosures; (3) Electrically controlled egress doors; (4) Door assemblies with special locking arrangements subject to 7.2.1.6.	K 761		

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K 761	Continued From page 23 -7.2.1.15.2 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. -7.2.1.15.3 The inspection and testing interval for fire-rated and non-rated door assemblies shall be permitted to exceed 12 months under a written performance-based program in accordance with 5.2.2 of NFPA 80, Standard for Fire Doors and Other Opening Protectives. -7.2.1.15.4 A written record of the inspections and testing shall be signed and kept for inspection by the authority having jurisdiction. NFPA 105 (2010) 5.2.1.1 Smoke door assemblies shall be inspected annually; 5.2.1.2 Doors shall be operated to confirm full closure; 5.2.1.3 Hardware and gaskets shall be inspected annually, and any parts found to be damaged or inoperative shall be replaced; 5.2.1.4 Tin clad and Kalamein doors shall be inspected regularly for dry rot; 5.2.1.5 A written record shall be maintained and shall be made available to the authority having jurisdiction; 5.2.1.6 Records shall be maintained for not less than three years.	K 761		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing	K 918		

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K 918	Continued From page 24 The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to properly document monthly generator exercises under load and weekly visual inspections, in accordance with NFPA 110. This deficient practice had the	K 918		

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K 918	Continued From page 25 potential to affect all residents, staff and any other occupants in the event of an emergency. The facility has a capacity of 115 and had a census of 87 residents at the time of the survey. Observation on 4/16/24 between 7:00 A.M. to 4:00 P.M. showed the facility featured an emergency generator, powered by propane. Review of the facility's generator inspection records showed the following: -Weekly inspections documented from 1/5/24 to 2/28/24; -No documented weekly inspections from 2023; -No documented monthly load tests from 2023 to 2024. During an interview on 4/17/24 at 9:00 A.M., the Maintenance Director said he was not able to locate any other documentation of the generator inspections and testing. He had been doing monthly load tests with the generator since he started (January 2024), but he knew he was not documenting them correctly. During an interview on 4/16/24 at 3:30 P.M., the Administrator said they have had two former Maintenance Directors leave with supplies, and they think the last Maintenance Director did something with the maintenance log books when he left. They were having difficulties locating all of the past paperwork. NFPA 110 (2010) 8.3.1* The Emergency Power Supply Systems (EPSSs) shall be maintained to ensure to a reasonable degree that the system is capable of supplying service within the time specified for the type and for the time duration specified for the class.	K 918		

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K 918	Continued From page 26 NFPA 110 (2010): A.8.3.1(a) Suggested Maintenance Schedule for EPSSs NFPA 110 (2010): 8.3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established. NFPA 110 (2010): 8.3.4 A permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. NFPA 110 (2010) 8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including appurtenant components, shall be inspected weekly and exercised under load at least monthly. NFPA 99 (2012) 6.4.4.2 Record Keeping: A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.	K 918		
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 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	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265719	A. BUILDING **01** B. WING _____	**04/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBERWOOD ESTATES NURSING AND REHABILITATION	**5303 BERMUDA DRIVE** **NORMANDY, MO 63121**

(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
K 920	Continued From page 27 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 and interview, the facility did not prohibit the use of extension cords and plugged motorized appliances into power strips. This had the potential to affect all occupants in the building. The facility has a capacity of 115 and had a census of 87 residents at the time of the survey. Observations during the Life Safety Code tour on 4/16/24 from 7:00 A.M. to 4:00 P.M., showed the following: -In the 500 hall medical records room, a microwave plugged into an orange extension cord; -In room 309, a television plugged into a white extension cord; -In the medication room at the main nurses' station, a mini-refrigerator plugged into a power strip; -In the supply room near the main nurses' station, a power supply charger plugged into a red extension cord; -In the 100 hall Day Room/office, a mini-refrigerator plugged into a power strip. During an interview on 4/17/24 at 11:00 A.M., the Regional Maintenance Director said their expectation was that extension cords are not	K 920		

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	265719	A. BUILDING **01** B. WING _____	**04/18/2024**

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AMBERWOOD ESTATES NURSING AND REHABILITATION	**5303 BERMUDA DRIVE** **NORMANDY, MO 63121**

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K 920	Continued From page 28 allowed and nothing with a motor should be plugged into a power strip. This expectation was part of their orientation training with staff. NFPA 70 400.8 Uses Not Permitted. 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.	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01238	A. BUILDING: 01 B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBERWOOD ESTATES NURSING AND REHABILITAT	5303 BERMUDA DRIVE NORMANDY, MO 63121

(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
A1086	19 CSR 30-85.012(79) LSC Edition Required per Date of Fac Plan All facilities with plans approved between June 10, 1981 and December 31, 1998, shall comply with the 1985 edition of the Life Safety Code, and all new facilities with plans approved on or after January 1, 1999, shall comply with the 1997 edition of the Life Safety Code (National Fire Protection Association NFPA 101), which are incorporated by reference in this rule. No provision of the 1997 code will be enforced if it is more restrictive than the code of original plan approval. Facilities may only use the fire safety evaluation system found in the 1995 NFPA 101A, incorporated by reference in this rule, if necessary to justify variance from the text of the Life Safety Code and not as a guide for the total design of a new facility. II This regulation is not met as evidenced by: See the deficiencies cited at K161, K222, K363, K761, K918, K920.	A1086		
A2008	19 CSR 30-85.022(4) Hazardous Areas Hazardous areas shall be separated by construction of at least one- (1-) hour fireresistant construction. Hazardous areas may be protected by an automatic sprinkler system in lieu of a one- (1-) hour rated fire-resistant construction. When the sprinkler option is chosen, the areas shall be separated from other spaces by smoke-resistant partitions and doors. The doors shall be self-closing or automatic closing. II This regulation is not met as evidenced by: See the deficiency cited at K321.	A2008		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBERWOOD ESTATES NURSING AND REHABILITA	5303 BERMUDA DRIVE NORMANDY, MO 63121

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A2016	Continued From page 1	A2016		
A2016	19 CSR 30-85.022(8)(D) Fire Extinguisher UL/FM, Monthly Check Fire Extinguishers. (D) All fire extinguishers shall bear the label of the UL or the FM Laboratories and shall be installed and maintained in accordance with NFPA 10, 1998 edition. This includes the documentation and dating of a monthly pressure check. II/III This regulation is not met as evidenced by: Class II* See the deficiency cited at K355.	A2016		
A2034	19 CSR 30-85.022(11)(C) Sprinkler System-Test/Maintain Sprinkler System. (C) Facilities that have a sprinkler system installed prior to August 28, 2007, shall inspect, maintain, and test these systems in accordance with the requirements in effect for such facilities on August 27, 2007. I/II This regulation is not met as evidenced by: Class II See the deficiency cited at K352.	A2034		
A2050	19 CSR 30-85.022(25) Emergency Lighting Facilities shall have emergency lighting of sufficient intensity to provide for the safety of residents and other people using any exit, stairway, and corridor. The lighting shall be supplied by an emergency service, an automatic emergency generator or battery lighting system.	A2050		

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AMBERWOOD ESTATES NURSING AND REHABILITA	5303 BERMUDA DRIVE NORMANDY, MO 63121

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A2050	Continued From page 2 This emergency lighting system shall be equipped with an automatic transfer switch. In an existing licensed facility, battery lights, if used, shall be wet cell units or other rechargeable-type batteries that shall be UL-approved and capable of operating the light for at least one and one-half (1½) hours. Battery-operated emergency lighting shall be tested for at least thirty (30) seconds every thirty (30) days, and an annual function test shall be conducted for the full operational duration of one and one-half (1½) hours. Records of these tests shall be documented and maintained for review. II This regulation is not met as evidenced by: See the deficiency cited at K291.	A2050		
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 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: See the deficiency cited at 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	A2057		

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AMBERWOOD ESTATES NURSING AND REHABILITA1	5303 BERMUDA DRIVE NORMANDY, MO 63121

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A2057	Continued From page 3 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* See the deficiency cited at K741.	A2057		
A2058	19 CSR 30-85.022(33)(A) Fire Drill/Emergency Preparedness - Plans Fire Drills and Emergency Preparedness. (A) All facilities shall have a written plan to meet potential emergencies or disasters and shall request consultation and assistance annually from a local fire unit for review of fire and evacuation plans. If the consultation cannot be obtained, the facility shall inform the state fire marshal in writing and request assistance in review of the plan. An up-to-date copy of the facility ' s entire plan shall be provided to the local jurisdiction ' s emergency management director. II/III This regulation is not met as evidenced by: Class II* Based on interview and record review, the facility failed to have an annual consultation of its emergency plans with the local fire unit, or the state fire marshal if the local fire unit was unavailable. This deficiency had the potential to affect all building occupants in the event of an emergency. The facility has a capacity of 115 and had a census of 87 residents at the time of the survey. Review of the facility's maintenance records on	A2058		

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A2058	Continued From page 4 4/16/24 at 2:30 P.M., showed no documentation of an annual consultation or request for an annual consultation from the fire department or the fire marshal's office. During an interview on 4/16/24 at 3:00 P.M., the Maintenance Director said the fire department had not come to the facility for a consultation since he worked there (January 2024), but he would see if he could locate a previous one. Review of an email from the Maintenance Director to the local fire unit, dated 4/16/24 at 4:03 P.M., provided by the Maintenance Director, showed he requested an annual fire department consultation for the facility. During an interview on 4/17/24 at 9:10 A.M., the Maintenance Director said he just sent an email to request an annual fire department consultation. He did not know when the last fire department consultation occurred. During an interview on 4/16/24 at 3:30 P.M., the Administrator said they have had two former Maintenance Directors leave with supplies, and they think the last Maintenance Director did something with the maintenance log books when he left. They were having difficulties locating all of the past paperwork.	A2058		
A2063	19 CSR 30-85.022(33)(F) Fire Drill Records (F) The facility shall keep a record of all fire drills including the simulated resident evacuation. The record shall include the time, date, personnel participating, length of time to complete the fire drill, and a narrative notation of any special problems. III	A2063		

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A2063	Continued From page 5 This regulation is not met as evidenced by: See the deficiency cited at K712. *The higher classification merited due to the extent of the violation.	A2063		

PLAN OF CORRECTION

Provider/Supplier Name:	Amberwood Estates Nursing and Rehabilitation
Street Address, City, Zip:	5303 Bermuda Drive, Normandy, MO 63121
Date of Survey:	4/18/24

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265719

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	
E 004	**1. The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** a. The annual update completed for the Emergency Operations Plan (EOP). **2. The corrective actions for other resident(s) having the potential to be affected by the same deficient practice includes:** **a.** The facility has determined that all residents have the potential to be affected. **3. Measures put into place to ensure that the deficient practice does not recur includes:** **a.** RDO/Designee to in-service the NHA on the requirement to update the EOP annually. **4. The Facility will monitor its performance to make sure that the solutions are sustained by conducting the following:** a. NHA/Designee to monitor the EOP thru facility audit tools monthly x 3 months to ensure changes are updated timely. Deficiencies found will be corrected immediately. Monitored findings will be brought to the QAPI committee for review.	5/28/24

K161	**1. The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** a. The wall near the 500 hall soiled utility room is repaired. **2. The corrective actions for other resident(s) having the potential to be affected by the same deficient practice includes:** **a.** The facility has determined that all residents have the potential to be affected. **3. Measures put into place to ensure that the deficient practice does not recur includes:** **a.** NHA/Designee to in-service the Maintenace Director on ensuring smoke/fire barrier walls are repaired timely with smoke/fire resistant materials. **4. The Facility will monitor its performance to make sure that the solutions are sustained by conducting the following:** **a.** Maintenance Director/Designee to monitor thru facility audit tools weekly x 4 weeks and monthly x 2 months to ensure walls are repaired timely. Deficiencies found will be corrected immediately. Monitored findings will be brought to the QAPI committee for review.	5/28/24

K222	**1. The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** a. The front exit door is repaired. b. The sandbag was removed from in front of the back exit door near room 500. Repairs to the door have been scheduled with the vendor for 5/13/24. Should repairs exceed the date of compliance a waiver will be submitted. **2. The corrective actions for other resident(s) having the potential to be affected by the same deficient practice includes:** **a.** The facility has determined that all residents have the potential to be affected. **3. Measures put into place to ensure that the deficient practice does not recur includes:** **a.** NHA/Designee to in-service the Maintenace Director on ensuring delayed egress functions are operating properly and exit doors are free from obstructions. **b.** Maintenance Director/Designee to in-service staff to ensure exit doors are free from obstruction. **4. The Facility will monitor its performance to make sure that the solutions are sustained by conducting the following:** **a.** Maintenance Director/Designee to monitor thru facility audit tools weekly x 4 weeks and monthly x 2 months to delay egress doors are functioning properly and exit doors are free from obstruction. Deficiencies found will be corrected immediately. Monitored findings will be brought to the QAPI committee for review.	5/28/24

K291	**1. The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** a. The monthly emergency lighting test was completed on 5/7/24. b. The battery operated emergency lights in the medication room at the nurses station was repaired. c. The battery operated emergency lights in the main electrical/generator transfer switch room was repaired. d. The exterior light at the back dining room door exit was repaired. **2. The corrective actions for other resident(s) having the potential to be affected by the same deficient practice includes:** **a.** The facility has determined that all residents have the potential to be affected. **3. Measures put into place to ensure that the deficient practice does not recur includes:** **a.** NHA/Designee to in-service the Maintenace Director on completing the monthly emergency lighting test and ensuring repairs are completed timely. **4. The Facility will monitor its performance to make sure that the solutions are sustained by conducting the following:** **a.** Maintenance Director/Designee to monitor thru facility audit tools monthly x 3 months to ensure the emergency lighting test is completed and repairs are completed as identified. Deficiencies found will be corrected immediately. Monitored findings will be brought to the QAPI committee for review.	5/28/24

K321	**1. The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** a. The medical records were removed from the beauty shop. **2. The corrective actions for other resident(s) having the potential to be affected by the same deficient practice includes:** **a.** The facility has determined that all residents have the potential to be affected. **3. Measures put into place to ensure that the deficient practice does not recur includes:** a. NHA/Designee to in-service the Maintenace Director on maintaining hazardous areas with corridor doors equipped with self-closing devices. **4. The Facility will monitor its performance to make sure that the solutions are sustained by conducting the following:** a. Maintenance Director/Designee to monitor thru facility audit tools monthly x 3 months to ensure hazardous areas are maintained with corridor doors equipped with self-closing devices. Deficiencies found will be corrected immediately. Monitored findings will be brought to the QAPI committee for review.	5/28/24

K352	**1. The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** **a.** The supervisory low air pressure switch was repaired. **2. The corrective actions for other resident(s) having the potential to be affected by the same deficient practice includes:** **a.** The facility has determined that all residents have the potential to be affected. **3. Measures put into place to ensure that the deficient practice does not recur includes:** **a.** NHA/Designee to in-service the Maintenace Director on ensuring deficiencies identified in sprinkler inspections are repaired timely. **4. The Facility will monitor its performance to make sure that the solutions are sustained by conducting the following:** **a.** Maintenance Director/Designee to monitor thru facility audit tools monthly x 3 months to deficiencies identified in sprinkler inspections are repaired timely as identified. Deficiencies found will be corrected immediately. Monitored findings will be brought to the QAPI committee for review.	5/28/24

K355	**1. The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** a. The monthly fire extinguisher checks were completed on the fire extinguishers in the following areas: Near the telephone room, Outside of the kitchen, near room 312, near room 517, near the main nurses' station, near room 107. **2. The corrective actions for other resident(s) having the potential to be affected by the same deficient practice includes:** **a.** The facility has determined that all residents have the potential to be affected. **3. Measures put into place to ensure that the deficient practice does not recur includes:** **a.** NHA/Designee to in-service the Maintenace Director on the fire extinguisher policy to include monthly inspections. **4. The Facility will monitor its performance to make sure that the solutions are sustained by conducting the following:** **a.** Maintenance Director/Designee to monitor thru facility audit tools monthly x 3 months to ensure monthly fire extinguisher inspections are completed. Deficiencies found will be corrected immediately. Monitored findings will be brought to the QAPI committee for review.	5/28/24

K363	**1. The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** a. The weight was removed from in front of the therapy room door. b. The 100 hall day room/office door was repaired. c. The 100 hall day room/break room was repaired. d. The conference room door was repaired. e. The plastic container was removed from the floor in front of the housekeeping office door. **2. The corrective actions for other resident(s) having the potential to be affected by the same deficient practice includes:** **a.** The facility has determined that all residents have the potential to be affected. **3. Measures put into place to ensure that the deficient practice does not recur includes:** **a.** NHA/Designee to in-service the Maintenace Director on door inspections to include maintaining corridor doors to ensure there are no obstructions that would prevent the closing of the doors and are maintained free from holes. **b.** The Maintenance Director/Designee to in-service the staff to ensure there are no impediment to the closing of the doors. 4. **The Facility will monitor its performance to make sure that the solutions are sustained by conducting the following:** a. Maintenance Director/Designee to monitor thru facility audit tools weekly x 4 weeks and monthly x 2 months to ensure corridor doors are maintained free from obstructions and holes. Deficiencies found will be corrected immediately. Monitored findings will be brought to the QAPI committee for review.	5/28/24

K372	**1. The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** a. The smoke damper in the attic space at the 100 hall smoke barrier wall was inspected and parts were order by the vendor with a lead time of 6-8 weeks for parts. A waiver has been submitted. b. The self-closing spring on the access door in the wall near the 400/500 hall nurses' station was repaired. **2. The corrective actions for other resident(s) having the potential to be affected by the same deficient practice includes:** **a.** The facility has determined that all residents have the potential to be affected. **3. Measures put into place to ensure that the deficient practice does not recur includes:** **a.** NHA/Designee to in-service the Maintenace Director on smoke barriers to include ensuring smoke dampers are functioning and smoke barrier wall access doors are self-closing. 4. **The Facility will monitor its performance to make sure that the solutions are sustained by conducting the following:** a. Maintenance Director/Designee to monitor thru facility audit tools weekly x 4 weeks and monthly x 2 months to ensure corridor doors are maintained free from obstructions and holes. Deficiencies found will be corrected immediately. Monitored findings will be brought to the QAPI committee for review.	7/21/24

K712	**1. The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** a. Day shift fire drill completed on 5/8/24 at 1:20pm b. Evening shift fire drill will be completed on 5/10/24. c. Night shift fire drill completed on 5/8/24 at 5:00am. **2. The corrective actions for other resident(s) having the potential to be affected by the same deficient practice includes:** **a.** The facility has determined that all residents have the potential to be affected. **3. Measures put into place to ensure that the deficient practice does not recur includes:** **a.** NHA/Designee to in-service the Maintenace Director on fire drills to include ensuring fire drills are completed on each shift, quarterly. 4. **The Facility will monitor its performance to make sure that the solutions are sustained by conducting the following:** a. Maintenance Director/Designee to monitor thru facility audit tools monthly x 3 months to ensure fire drills are completed each shift. Deficiencies found will be corrected immediately. Monitored findings will be brought to the QAPI committee for review.	5/28/24

K741	**1. The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** a. Metal trash cans have been removed from the smoking area and replaced with metal containers with self-closing cover devices. b. The cigarette butts on the the sidewalk area near the main nurses' station were disposed of. **2. The corrective actions for other resident(s) having the potential to be affected by the same deficient practice includes:** **a.** The facility has determined that all residents have the potential to be affected. **3. Measures put into place to ensure that the deficient practice does not recur includes:** **a.** NHA/Designee to in-service the Maintenace Director on providing/maintaining metal containers with self-closing cover devices remain free of trash. **b.** NHA/Designee to in-service the Maintenance Director and Housekeeping Director on ensuring the grounds are free from cigarette butts. 4. **The Facility will monitor its performance to make sure that the solutions are sustained by conducting the following:** a. Maintenance Director/Designee to monitor thru facility audit tools monthly x 3 months to ashtrays with self-closing cover devices remain free of trash and grounds remain free from cigarette butts. Deficiencies found will be corrected immediately. Monitored findings will be brought to the QAPI committee for review.	5/28/24

K761	**1. The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** a. The annual door inspection is scheduled for 5/10/24 & 5/13/24. **2. The corrective actions for other resident(s) having the potential to be affected by the same deficient practice includes:** **a.** The facility has determined that all residents have the potential to be affected. **3. Measures put into place to ensure that the deficient practice does not recur includes:** **a.** NHA/Designee to in-service the Maintenace Director on completion of annual door inspections to include ensuring deficiencies are repaired in a timely manner. 4. **The Facility will monitor its performance to make sure that the solutions are sustained by conducting the following:** a. Maintenance Director/Designee to monitor thru facility audit tools monthly x 3 months to ensure the annual door inspection is completed and deficiencies are repaired timely as identified. Monitored findings will be brought to the QAPI committee for review.	5/28/24

K918	**1. The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** a. The monthly generator test under load was completed and will continue monthly as scheduled. b. The weekly generator inspection was completed and will continue weekly as scheduled. **2. The corrective actions for other resident(s) having the potential to be affected by the same deficient practice includes:** **a.** The facility has determined that all residents have the potential to be affected. **3. Measures put into place to ensure that the deficient practice does not recur includes:** **a.** NHA/Designee to in-service the Maintenace Director on the facility's emergency generator testing policy. 4. **The Facility will monitor its performance to make sure that the solutions are sustained by conducting the following:** a. Maintenance Director/Designee to monitor thru facility audit tools monthly x 3 months to ensure weekly and monthly generators tests are completed. Deficiencies found will be corrected immediately. Monitored findings will be brought to the QAPI committee for review.	5/28/24

K920	**1. The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** a. The extension cord was removed from the 500 hall medical records room. b. The extension cord in room 309 was removed. c. The power strip was removed from the medication room at the main nurses' station. d. The extension cord was removed from the supply room near the main nurses' station. e. The power strip was removed from the 100 hall day room/office. **2. The corrective actions for other resident(s) having the potential to be affected by the same deficient practice includes:** **a.** The facility has determined that all residents have the potential to be affected. **3. Measures put into place to ensure that the deficient practice does not recur includes:** **a.** NHA/Designee to in-service the Maintenace Director on the facility's electrical safety policy to include the use of extension cords. **b.** Maintenance Director to in-service staff on the facility's electrical safety policy to include the use of extension cords. 4. **The Facility will monitor its performance to make sure that the solutions are sustained by conducting the following:** a. Maintenance Director/Designee to monitor thru facility audit tools weekly x 4 weeks and monthly x 2 months. Deficiencies found will be corrected immediately. Monitored findings will be brought to the QAPI committee for review.	5/28/24

A1086	**See corresponding POC for K161, K222, K363, K761, K918, K920**	
A2008	**See corresponding POC for K321**	
A2016	**See corresponding POC for K355**	
A2034	**See corresponding POC for K352**	
A2050	**See corresponding POC for K291**	
A2054	**See corresponding POC for K372**	
A2057	**See corresponding POC for K741**	
A2058	**1. The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** a. The annual consultation with the local fire unit was completed on 4/22/24. **2. The corrective actions for other resident(s) having the potential to be affected by the same deficient practice includes:** **a.** The facility has determined that all residents have the potential to be affected. **3. Measures put into place to ensure that the deficient practice does not recur includes:** **a.** NHA/Designee to in-service the Maintenace Director on the requirement for annual consultation with the local fire unit. 4. **The Facility will monitor its performance to make sure that the solutions are sustained by conducting the following:** a. Maintenance Director/Designee to monitor thru facility audit tools monthly x 3 months. Deficiencies found will be corrected immediately. Monitored findings will be brought to the QAPI committee for review.	5/28/24
A2063	**See corresponding POC for K712**	

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.