STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415087	A. BUILDING _____ B. WING _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENVILLE SKILLED NURSING AND REHABILITATION	735 PUTNAM PIKE GREENVILLE, RI 02828

(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
F 000	INITIAL COMMENTS A recertification and complaint survey, ACTS reference number 98627, was conducted at Greenville Skilled Nursing Home on 12/2/2024 through 12/5/2024 to determine compliance with 42 C.F.R. Part 483, requirements for Long Term Care Facilities. A state licensure and emergency preparedness survey was also conducted at this facility. Deficiencies were identified as a result of these surveys.	F 000	This plan of correction is prepared and submitted as required by law. By submitting this Plan of Correction, Greenville Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.	
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that residents who require dialysis (a procedure to remove waste products and excess fluids from the blood when the kidneys stop working properly) receive such services, consistent with professional standards of practice for 2 of 2 residents reviewed, Resident ID #s 11 and 32. Findings are as follows: 1. Record review revealed Resident ID #32 was admitted to the facility in September of 2024 with diagnoses including, but not limited to, end stage	F 698	12/24/24 Received DEC 23 2024 Facilities Regulation	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/23/24

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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F 698	Continued From page 1 renal disease and dependence on renal dialysis. Further record review revealed the resident receives outpatient dialysis three times a week on Tuesday, Thursday, and Saturday. Record review revealed the resident has an Arteriovenous Fistula (AVF; a connection between an artery and a vein for dialysis access) to his/her right upper extremity for dialysis treatments. a) Review of the care plan revealed interventions to monitor his/her AVF for bruit (a whooshing sound that is heard through a stethoscope indicating turbulent blood flow in an artery) and thrill (a vibration felt on the skin overlying an area with turbulent blood flow) every shift and as needed. Review of the resident's progress notes from 11/1/2024 to 12/2/2024 revealed that the resident's bruit and thrill were not assessed for 95 out of 96 opportunities. b) Review of the facility's policy titled, "Dialysis: Hemodialysis (HD) Provided by a Certified End Stage Renal Disease (ESRD) Facility" revealed that the care of the resident receiving HD must reflect ongoing communication, coordination, and collaboration between the nursing facility and the dialysis center staff including advance directives and code status. Review of a MOLST (Medical Orders for Life Sustaining Treatment) form located in Resident ID #32's medical chart dated 9/16/2024 indicated, do not attempt resuscitation (DNR).	F 698	Resident #32 and # 11 are Safe within the Center, Bruit and Thrill is being monitored along with their fluid intake and documented daily with total intake, additionally resident # 32 A current accurate copy of MOLST was placed in the resident dialysis communication binder. Facility wide audits will be conducted to identify residents who have potential to be affected. Licensed staff education will completed on the care of Hemo-Dialysis Patients, including updating of communication binder whenever there are changes in resident wishes such as advanced directives, assessment of AVF for Bruit and Thrill, fluid intake to ensure residents who have orders for fluid restriction, their daily fluid intake is monitored and documented. A weekly audit will be completed x4 then monthly x2 . The results of the audits will be presented to the QAPI for further recommendations. The Director of Nursing / Designee will oversee the process.	1/3/2025

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F 698	Continued From page 2 Review of Resident ID #32's dialysis communication binder revealed a MOLST form dated 9/6/2024 indicated, attempt cardiopulmonary resuscitation (CPR). During a surveyor interview with the Director of Nursing Services (DNS) on 12/3/2024 at 12:26 PM, she acknowledged that the resident was a DNR and the most recent MOLST form, dated 9/16/2024 indicating the updated DNR status, should have been placed in the dialysis communication book. c) According to the National Kidney Foundation "...fluid overload in dialysis patients occurs when too much water builds up in the body. It can cause swelling, high blood pressure, breathing problems, and heart issues. Having too much water in your body is called fluid overload or hypervolemia...That's why it's so important to limit how much sodium (salt) and fluid you have between dialysis treatments...Follow the fluid guidelines given to you by your healthcare team. Most dialysis patients need to limit their fluid intake to 32 ounces per day..." Record review failed to reveal evidence of a fluid restriction for Resident ID #32 from 11/1/2024 to 12/2/2024. Further record review revealed during the survey process a fluid restriction order was initiated for Resident ID #32 on 12/3/2024. During a surveyor interview on 12/3/2024 at 2:20 PM with Registered Nurse, Staff A, she was unable to provide evidence that the facility was monitoring the resident's fluid intake from 11/1/2024 to 12/2/2024.	F 698		

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F 698	Continued From page 3 During a surveyor interview on 12/3/2024 at 2:30 PM with Resident ID #32's Dialysis Clinical Manager, she revealed that she would expect the resident to be on a fluid restriction, as s/he receives dialysis. During a surveyor interview on 12/3/2024 at 2:42 PM with the DNS, she was unable to provide evidence that the facility was monitoring the resident's fluid intake from 11/1/2024 to 12/2/024, or assessing the AVF for a bruit and thrill. 2. Record review revealed Resident ID #11 was admitted to the facility in January of 2021 with diagnosis including, but is not limited to, chronic kidney disease, stage 4 (kidneys are severely damaged and minimally functioning). Further record review revealed Resident ID #11 receives outpatient dialysis three times a week, on Tuesday, Thursday, and Saturday. Record review revealed a physician's order dated 7/23/2024 for a 1500 mL fluid restriction daily, indicating that the resident should not exceed the following fluid totals in a 24-hour period: -Nursing: 780 mL -Dietary: 720 mL Record review failed to reveal evidence that the facility was monitoring Resident ID #11's total daily fluid intake, until after it was brought to the facility's attention, on 12/3/2024. During a surveyor observation on 12/3/2024 at 12:13 PM of Resident ID #11, s/he was observed in his/her room with the following fluids at his/her	F 698		

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F 698	Continued From page 4 bedside: - 180 mL of apple juice - 180 mL of milk - 480 mL of water Additional observation on 12/3/2024 at 12:23 PM revealed the following fluids served with his/her lunch meal: - 180 mL of ginger ale - 240 mL of coffee Record review failed to reveal evidence that the above fluids were recorded and monitored until it was brought to the facility's attention by the surveyor. During surveyor interviews on 12/3/2024 at 12:31 PM and 12:45 PM with Registered Nurse, Staff B, she acknowledged that Resident ID #11 is on a fluid restriction but failed to provide documentation of his/her total fluid intake, and that it should be monitored. During a surveyor interview on 12/3/2024 at 12:54 PM with the DNS, she was unable to provide evidence that the facility was monitoring Resident ID #11's fluid intake. During a surveyor interview on 12/3/2024 at 1:54 PM with Resident ID #11's Physician, he revealed that he would expect the facility to monitor and document the resident's fluid intake, every shift.	F 698		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General.	F 757		

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F 757	Continued From page 5 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to ensure that the resident's drug regimen is free from unnecessary drugs for 1 of 1 resident reviewed for a medication with parameters, Resident ID #23. Findings are as follows: Record review revealed that the resident was readmitted to the facility in July of 2023 with diagnoses including, but not limited to, dementia and hypotension (low blood pressure; blood pressure lower than 90/60). Review of a physician's order dated 9/16/2024	F 757	Resident # 23 is safe within the Center, blood pressure parameters being monitored and adhered to. A facility wide audit of residents will be completed to identify residents who may have a potential to be affected. licensed staff Education will be completed on following MD orders with all medications that have parameters. A weekly audit will be completed x4, then monthly x2 to ensure that all medication orders with parameters are adhered to, the results of the audits will be presented at Center QAPI. The Director of Nursing or Designee will oversee the process.	1/3/2025

12/24/24

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F 757	Continued From page 6 revealed Midodrine 5 milligrams (mg), give one tablet three times daily for hypotension with parameters to hold the medication if the systolic blood pressure (SBP; top number/pressure when the heart beats) is greater than 120. Review of the November and December 2024 Medication Administration Records (MAR) revealed that the resident was administered the Midodrine when the resident's SBP indicated it should be held based on the parameters on the following dates and times: 11/2/2024 - Evening (Blood Pressure (BP) 132/80) 11/3/2024 - Evening (BP 124/80) 11/4/2024 - Evening (BP 122/80) 11/5/2024 - Morning (BP 122/60) Evening (BP 128/78) 11/6/2024 - Evening (BP 142/68) 11/7/2024 - Evening (BP 130/80) 11/8/2024 - Evening (BP 122/64) 11/11/2024 - Evening (BP 132/74) 11/12/2024 - Evening (BP 128/78) 11/14/2024 - Evening (BP 126/70) 11/15/2024 - Afternoon (BP 142/60) 11/16/2024 - Morning (BP 138/78) 11/17/2024 - Evening (BP 128/70) 11/18/2024 - Morning (BP 132/80) Afternoon (BP 132/80) 11/19/2024 - Afternoon (BP 128/62) 11/22/2024 - Evening (BP 122/78) 11/23/2024 - Evening (BP 128/72) 11/24/2024 - Evening (BP 136/76) 11/26/2024 - Evening (BP 161/120) 11/29/2024 - Morning (BP 122/71) Evening (BP 136/76) 12/2/2024 - Evening (BP 122/58)	F 757		

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F 757	Continued From page 7 During a surveyor interview on 12/3/2024 at 12:30 PM with Registered Nurse, Staff C, she acknowledged that Midodrine should not have been administered due to the resident's blood pressure being outside of the parameters. During a surveyor interview on 12/3/2024 at 12:42 PM with the Director of Nursing Services, she was unable to provide evidence that the facility's staff followed the physician's order for administering the Midodrine. During a surveyor interview on 12/3/2024 at 1:54 PM via the telephone with the resident's Physician, he revealed that he was unaware that the staff was administering the Midodrine outside of the parameters ordered. Additionally, he revealed that he would expect staff to follow the order as written.	F 757		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, resident and staff interview, it has been determined that the facility failed to accommodate residents' food preferences for 2 of 5 residents,	F 806		

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F 806	Continued From page 8 Resident ID #s 28 and 30. Findings are as follows: Record review of the facility policy titled, "Dining and Food Preferences" revised on 10/2022, revealed that individual dining, food, and beverage preferences are identified for all residents. The individual tray assembly ticket will identify all food items appropriate for the residents based on diet order and preferences. 1. Record review revealed that Resident ID #28 was admitted to the facility in September of 2021 with a diagnosis including, but is not limited to, anxiety disorder. Record review of the Quarterly Minimum Data Set (MDS) assessment dated 9/20/2024 revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition. During a surveyor interview at the resident council meeting on 12/3/2024 at approximately 1:00 PM with Resident ID #28, s/he revealed that s/he has told the dietary and nursing staff that s/he dislikes eggs and continues to receive them during meals. Record review of Resident ID #28's meal ticket on 12/4/2024 at 8:44 AM, revealed that s/he was not supposed to receive eggs with meals and was supposed to receive pancakes instead. During a surveyor observation of the breakfast meal pass on 12/4/2024 at 8:44 AM, Resident ID #28 was served two boiled eggs and failed to receive pancakes, as preferred.	F 806 12/24/24	Resident #28 and # 30 are safe within the center receiving their meals of choice/preferences. Facility wide audit will be completed to assure no other resident has potential to be affected. Staff in the dietary department, nursing, recreation, and social services will be educated on the importance of following residents' likes and dislikes, reading meal tickets to ensure residents are served with meals of their choice. A weekly audit will be conducted x4 then monthly x 2 months the results of the audit will be presented to the center QAPI. The FSD/ Or Designee will oversee the process.	1/3/2025

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F 806	Continued From page 9 During a surveyor interview on 12/4/2024 at 8:48 AM with Registered Nurse, Staff B, she revealed that the dietary aides set up the individual tray assemblies and was unsure why Resident ID #28 was served eggs and failed to receive pancakes, as preferred and indicated on the resident's meal ticket. 2. Record review revealed that Resident ID #30 was admitted to the facility in March of 2024 with a diagnosis including, but is not limited to, depression. Record review of the Quarterly MDS assessment dated 9/20/2024 revealed a score BIMS of 15 out of 15, indicating intact cognition. Record review of Resident ID #30's meal ticket on 12/2/2024 at 12:25 PM, revealed that s/he ordered a shredded pork sandwich and coleslaw. During a surveyor observation on 12/2/2024 at 12:29 PM, revealed that Resident ID #30 received a turkey patty. During a surveyor interview with the resident following the above observation, s/he revealed that s/he wanted the shredded pork sandwich and coleslaw for lunch but did not receive it and s/he stated that "half of the time" s/he does not get what s/he has ordered. During a surveyor interview on 12/4/2024 at 1:29 PM with the Regional Executive Chef, he acknowledged that Resident ID #28 failed to receive the meal listed on the meal ticket and would expect the meal tickets to reflect what the residents receive on their individual tray assemblies.	F 806		

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F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety relative to the main kitchen. Findings are as follows: 1. Record review of the Rhode Island Food Code 2018 Edition 4-601-11 states in part, "...Nonfood contact surfaces shall be kept free of an accumulation of dirt, dust, food residue and other debris..." Surveyor observations made during the initial tour	F 812	The main kitchen wall with black matter was cleaned fan in the dish room was cleaned immediately dust and debris removed, the build up debris/black colored grime in front of the steamer was cleaned, The hood slats above the stove with debris was cleaned. The unlabeled spray bottle with a pink cleaning agent was discarded. Kitchen audit was completed to ensure proper sanitation, storage and cleanliness is maintained. Dietary and Maintenance will be educated on maintaining proper sanitation, cleanliness, proper food storage to avoid contamination as well as develop a cleaning schedule of the walls, hood, fans. Additionally, staff will be educated on labeling and dating of any cleaning agents decanted from any source other than the original container from the manufacturer and maintain proper storage. Weekly audit of Kitchen sanitation will be completed x4 then monthly x2 the results of the audit to be presented at center QAPI. The FSD/ or designee. 12/24/24	1/3/2025

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F 812	Continued From page 11 of the main kitchen on 12/2/2024 at approximately 8:40 AM revealed the following: - the walls in the main kitchen and dish room had an accumulation of black matter - a fan located in the dish room had a significant built up of dust and debris, approximately one inch thick - a floor drain in front of the steamer had a buildup of approximately 1.5 inches of thick, grayish black colored grime. 2. Record review of the State Operations Manual Appendix PP-Guidance to Surveyors for Long term care Facilities 483.60(i)(1)-(2) states in part,"...chemical products and supplies, must be clearly marked..." Record review of the Occupational Safety and Health Administration Standard 1910.1200 (f)(1) states in part, "...chemicals are marked with a product identifier, signal word (danger or warning), a statement that the full label information for the chemical is provided on the outside package..." During a surveyor observation of the main kitchen on 12/2/2024 at approximately 8:40 AM, revealed a spray cleaning bottle with a pink colored substance which failed to have a label that included a signal word or a statement that the full label information for the chemical. During a surveyor interview on 12/5/2024 at approximately 11:11 AM with the Regional Executive Chef, he acknowledged that the walls, ceiling fan, and the floor drain needed to be	F 812		

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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
F 812	Continued From page 12 cleaned. Additionally, he acknowledged that the spray cleaning bottle failed to have the appropriate labeling.	F 812		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to establish an Infection Prevention and Control Program (IPCP) that must include an antibiotic stewardship program for antibiotic use protocols and a system to monitor antibiotic usage for 2 of 3 residents, Resident ID #s 23 and 27. Findings are as follows: 1. Review of a facility policy titled, "Antimicrobial Stewardship Program Long Term Care" last reviewed 7/1/2024 refers to the Centers for Disease Control and Prevention (CDC) document titled, "The Core Elements of Antibiotic Stewardship for Nursing Homes" regarding the facility's antibiotic stewardship procedure. This revealed that all antibiotics prescribed in the facility must be reviewed for the ongoing need for and choice of an antibiotic when the clinical picture is clearer, and more information is	F 881	Resident #23 and #27 are safe within the center. The facility has established an antibiotic stewardship program and monitoring antibiotic usage and time outs. Facility wide completed to identify any other residents who may have a potential to be affected. Education was provided to the Infection Preventionist on antibiotic stewardship program with all elements to assure judicious use of the antibiotics to reduce unintended risks i.e MDROs, appropriate use of antibiotics with the shortest length of therapy, efficacy, total residents number, and days, and maintain a line list. A weekly audit of antibiotic use will be completed x 4, then monthly x2, the results of the audits will be presented at Center QAPI. The Director of Nursing/or Designee will oversee the process.	1/3/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415087	A. BUILDING _____ B. WING _____	12/05/2024

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F 881	Continued From page 13 available (antibiotic time-out). a) Record review revealed that Resident ID #23 was readmitted to the facility in July of 2023 with diagnoses including, but not limited to, sepsis (blood infection) and urinary tract infection. Record review revealed the resident was started on Amoxicillin (antibiotic) 500 milligrams (mg) for 7 days for the treatment of a urinary tract infection. Record review failed to reveal evidence that an antibiotic time-out was completed following the initiation of the Amoxicillin for Resident ID #23, per the facility's policy. b. Record review revealed that Resident ID #27 was admitted to the facility in August of 2024 with a diagnosis including, but is not limited to, infection of the intervertebral disc (spine). Record review revealed a physician's order for Ciprofloxacin (antibiotic) 500 mg by mouth two times a day for a wound infection with a start date of 10/25/2024 and an end date of 11/22/2024. Record review failed to reveal evidence that an antibiotic time-out was completed following the initiation of the Ciprofloxacin for Resident ID #27, per the facility policy. During a surveyor interview on 12/5/2024 at 10:35 AM with the Director of Nursing Services (DNS), the Infection Preventionist, the Administrator, and the Market Lead Clinical Specialist, they acknowledged that the facility failed to complete antibiotic time-outs for Resident ID #s 23 and 27, per the facility policy.	F 881		

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F 881	Continued From page 14 2. Further record review of the CDC's document titled, "The Core Elements of Antibiotic Stewardship for Nursing Homes," recommends that the facility should have a tracking system related to antibiotic use, including days of therapy, to identify opportunities for improvement in determining the appropriateness of antibiotic therapy. Record review of the facility's IPCP failed to reveal evidence of a tracking system of antibiotic use that includes days of therapy. During surveyor interview on 12/4/2024 at 9:03 AM with the Infection Preventionist and the DNS, they revealed that they were unaware of the antibiotic days of therapy, and they do not track them.	F 881		

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by the Center for Health Facilities and Regulation on 12/3/2024. The facility was found to be in compliance with 42 CFR §483.73 related to Emergency Preparedness.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 12/23/24

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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	415087	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/03/2024

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K 000	INITIAL COMMENTS The annual Federal Life Safety Code survey was conducted by the State Survey Agency. Greenville Skilled Nursing and Rehabilitation was surveyed pursuant to the National Fire Protection Association 101 Life Safety Code, 2012 Edition as referenced in 42 CFR 483.90 (a - d) Physical Environment. A Life Safety Code deficiency was identified during the survey.	K 000		
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	K 363	12/24/24 The Smoke Door Separating Daisy unit and The Main Core of the Facility with a gap more than allowable ⅛ was rectified. Facility audits of Smoke doors were completed to assure no other door with more than ⅛ Gap. Maintenance staff will be educated on ensuring that smoke doors/ barriers meet NFPA and Life Safety Code requirements 2012. A monthly audit of all Smoke Barriers/ Doors will be conducted x 3, then Quarterly to assure no penetration gaps more than ⅛ on Doors the results of the audits will be presented at center QAPI. The Maintenance Director/ Designee will oversee the process.	1/3/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 12/23/24

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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K 363	Continued From page 1 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 surveyor observations, record review, and staff interview, it has been determined that the facility failed to maintain the smoke barrier doors and/or any of its components in accordance with the National Fire Protection Association (NFPA) 101 Life Safety Code, 2012 Edition. This deficient practice has the potential to impact 20 of 20 residents in 2 smoke zones, as well as an indeterminable number of staff and visitors. Findings are as follows: During a surveyor observation on 12/3/2024 at 10:05 AM, during the life safety tour, in the presence of the Maintenance Director, it revealed that the smoke doors separating the Daisy unit from the main core of the facility had a gap greater than the maximum allowable clearance of 1/8th of an inch. During a surveyor interview on 12/3/2024, immediately following the above observation, with	K 363		

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K 363	Continued From page 2 the Maintenance Director, he acknowledged that the smoke doors separating the Daisy unit from the main core of the facility, had a gap greater than the maximum allowable clearance of 1/8th of an inch, when in the closed position.	K 363		