| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255332 | A. BUILDING **01 - BUILDING 0101**<br>B. WING _____ | **06/25/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **HOLMES COUNTY LONG TERM CARE CENTER - DURANT** | **15481 BOWLING GREEN ROAD**<br>**DURANT, MS 39063** |

| (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 000 | INITIAL COMMENTS<br><br>42 CFR 483.70(a)<br><br>The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). | K 000 | | |
| K 355<br>SS=D | Portable Fire Extinguishers<br>CFR(s): NFPA 101<br><br>Portable Fire Extinguishers<br>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.<br>18.3.5.12, 19.3.5.12, NFPA 10<br>This REQUIREMENT is not met as evidenced by:<br>Based on the observation, the facility failed to provide portable fire extinguishers in accordance with NFPA 10 Standard for Portable Fire Extinguishers. This standard deficiency affected the entire facility on the day of the survey.<br><br>Findings Include:<br><br>On 6/25/24 at 9:35 AM, observation revealed that the facility failed to provide the annual inspection documentation for all fire extinguishers in the facility. The last known documented date for annual inspection of fire extinguisher was March 2023. | K 355 | 1. Upon fire extinguisher inspection on 06/25/2024 Johnson Control was notified and scheduled fire extinguisher inspection on 07/09/2024.<br><br>2. The facility has determined that all residents have the potential to be affected.<br><br>3. Maintenance supervisor will inspect fire extingishers monthly times 4 months begining July 10, 2024.<br><br>4. The results of each monthly fire extingisher inspection will be documented and kept in Quality Assurance binder in Administrators office. | 7/26/24 |
| K 372<br>SS=D | Subdivision of Building Spaces - Smoke Barrie<br>CFR(s): NFPA 101 | K 372 | | 7/26/24 |

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

Electronically Signed | 07/10/2024

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 372 | Continued From page 1<br>Subdivision of Building Spaces - Smoke Barrier Construction<br>2012 EXISTING<br>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system in REMARKS.<br>This REQUIREMENT is not met as evidenced by:<br>Based on the observation, the facility failed to provide half hour rating in the smoke barrier wall in accordance with NFPA 101 sections 19.3.7.3 and 8.5.6.2. This standard deficiency affected three (3) of six (6) smoke compartments in the facility on the day of Survey.<br><br>Findings Include:<br><br>On 6/25/24 at 10:10 AM, observation revealed unsealed holes around electrical piping and grey data cables at the following smoke barrier walls of the facility:<br><br>D Hall Smoke Barrier Wall<br><br>E Hall Smoke Barrier Wall<br><br>These smoke barrier walls were incapable of resisting the passage of smoke throughout the facility. | K 372 | 1.Upon inspection of the smoke barrier walls on 06/25/2024 maintenance supervisor sealed holes around electrical piping and grey data cables to D hall smoke barrier wall and E hall smoke barrier wall.<br><br>2. All residents have the potential to be affected by this deficient practice.<br><br>3. The maintenance supervisor will perform a weekly smoke barrier wall inspection on all 6 smoke compartments in facility weekly for 4 weeks then monthly for 3 months beginning 06/27/2024.<br><br>4. The results of each weekly and monthly smoke barrier wall inspection will be documented and kept in the Quality Assurance binder in the admisistrators office. | |

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