STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255126	A. BUILDING **01 - BUILDING 0101** B. WING _____	**02/08/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKINSON COUNTY SENIOR CARE	**116 SOUTH LAFAYETTE STREET** **CENTREVILLE, MS 39631**

(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 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to properly maintain exit egress as per NFPA 101 section 19.2.1, 7.1.10.1. This standard deficiency affected one (1) of five (5) exits and nine (9) of 68 residents in the facility on the day of survey. Findings include: On February 8, 2022, at 10:50 AM, observation revealed furniture blocking exit discharge (corridors/ hallways) in the Covid Unit Area of the facility. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on February 8, 2022.	K 211	A. The facility failed to properly maintain exit egress as per NFPA 101 section 19.2.1,7.1.10.1. On 2-8-2022 at 11:00 AM, Maintenance staff removed the furniture blocking exit discharge (corridors/hallways) in the Covid Unit Area of the facility. B. The potential exists to affect 68 residents. C. On 2-8-2022 at 11:00 AM, Maintenance staff removed the furniture blocking exit discharge (corridors/hallways) in the Covid Unit Area of the facility. The Maintenance Staff was in-serviced on 2-8-2022 by the Administrator to ensure all corridors and hallways were free of obstructions and open for egress. D. The Maintenance Staff and Administrator will conduct weekly rounds for four (4) weeks, then monthly rounds for three (3) months to ensure all corridors and hallways were free of obstructions and open for egress starting on	3/24/22

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

Electronically Signed | 03/17/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 211	Continued From page 1	K 211	3-21-2022. Starting on 4-2-2022, results of the above listed rounds and any necessary corrective action taken will be reviewed in the weekly Quality Assurance meetings by the Quality Assurance Performance Improvement Committee. Necessary changes will be made to maintain sustained compliance.	
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) f. Combustible Storage Rooms/Spaces	K 321		3/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255126	A. BUILDING **01 - BUILDING 0101** B. WING _____	**02/08/2022**

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K 321	Continued From page 2 (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to properly protect hazardous areas in accordance to NFPA 101 section 19.3.2.1.2. This deficiency affected two (2) of six (6) smoke compartments and 40 of 68 residents in the facility on the day of survey. Findings Include: On February 8, 2022, at 10:45 AM and 12:17 PM, observation revealed no self-closing devices (door closures) on the doors to the Gas Hot Water Heater Rooms near nurse stations A and B of the facility. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on February 8, 2022.	K 321	A. The facility failed to properly protect hazardous areas in accordance to NFPA 101 section 19.3.2.1.2 by not having self-closing devices (door closers) on the doors to the Gas Hot Water Heater Rooms near nurse stations A and B of the facility. B. The potential exists to affect 68 residents. C. On 2-11-2022, self-closing devices were installed in the doors to the Gas Hot Water Heater Rooms near nurse stations A and B of the facility in order to properly protect hazardous areas in accordance to NFPA 101 section 19.3.2.1.2. D. The Maintenance Staff and Administrator will conduct weekly rounds for four (4) weeks, then monthly rounds for three (3) months to ensure self-closing devices (door closers) on the doors to the Gas Hot Water Heater Rooms near nurse stations A and B of the facility are working as designed starting on 3-21-2022. Starting on 4-2-2022, results of the above listed rounds and any necessary corrective action taken will be reviewed in the weekly Quality Assurance meetings by the Quality Assurance Performance Improvement Committee. Necessary changes will be made to maintain sustained compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to have a properly installed components of the fire alarm system in accordance NFPA 101 sections 19.3.4.1, 9.6, 9.6.1.8 and NFPA72. This deficiency affected (4) of six (6) smoke compartments and 40 of 68 residents in the facility on the day of survey. Findings include: On February 8, 2022, between 10:15 AM and 2:00 PM, observation revealed smoke detectors were installed near and within 3 feet of return air grilles in the following areas of the facility: 1. Smoke detectors near Rooms 4 and15 on the A Hall of the facility	K 341	A. The facility failed to have properly installed components of the fire alarm system in accordance to NFPA 101 sections 19.3.4.1, 9.6,9.6.1.8 and NFPA 72. Smoke detectors are installed near and within three (3) feet of return air grilles in the following areas of the facility: 1. Smoke detectors near Rooms 4 & 15 2. Smoke detectors near Rooms 4 & 15 on B Hall of the facility. B. The potential exists to affect 68 residents. C. This facility has taken measures to have smoke detectors properly installed in	3/24/22

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K 341	Continued From page 4 2. Smoke detectors near Rooms 4 and15 on the B Hall of the facility The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on February 8, 2022.	K 341	accordance to NFPA 101 sections 19.3.4.1, 9.6,9.6.1.8 and NFPA 72.in these areas of the facility: 1. Smoke detectors near Rooms 4 & 15 2. Smoke detectors near Rooms 4 & 15 on B Hall of the facility. D. The Maintenance Staff and Administrator will conduct weekly rounds for four (4) weeks, then monthly rounds for three (3) months to ensure smoke detectors are working as designed starting on 3-21-2022. Starting on 4-2-2022, results of the above listed rounds and any necessary corrective action taken will be reviewed in the weekly Quality Assurance meetings by the Quality Assurance Performance Improvement Committee. Necessary changes will be made to maintain sustained compliance.	
K 347 SS=D	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to provide smoke detection systems in spaces open to corridors as required by NFPA 101 section 19.3.6.1. The deficient practice affected one (1) of six (6) smoke compartments and 9 of 68 residents in facility on the day of survey.	K 347	A. The facility failed to provide smoke detection systems in spaces open to corridors as required by NFPA 101 section 19.3.6.1. There is no smoke detector protecting the Snack Machine Room of the facility. The Snack Machine Room is	3/24/22

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K 347	Continued From page 5 Findings Include: On February 8, 2022, at 11:30 AM, observation revealed no hard-wired smoke detector protecting the Snack Machine Room of the facility. The Snack Machine Room were open to the main corridor and could not resist the passage of smoke throughout the facility. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on February 8, 2022.	K 347	open to the main corridor and cannot resist the passage of smoke throughout the facility. B. The potential exists to affect 68 residents. C. This facility has taken measures to have smoke detectors properly installed in accordance to NFPA 101 sections 19.3.4.1, 9.6,9.6.1.8 and NFPA 72.in the Snack Machine Room of the facility. D. The Maintenance Staff and Administrator will conduct weekly rounds for four (4) weeks, then monthly rounds for three (3) months to ensure smoke detectors are working as designed starting on 3-21-2022. Starting on 4-2-2022, results of the above listed rounds and any necessary corrective action taken will be reviewed in the weekly Quality Assurance meetings by the Quality Assurance Performance Improvement Committee. Necessary changes will be made to maintain sustained compliance.	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection	K 351		3/24/22

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K 351	Continued From page 6 measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to provide sprinkler system in accordance with the NFPA 13 section 13.6.2.9.3. This deficiency affected one (1) of six (6) smoke compartments in the facility on the day of survey. Findings include: On February 8, 2022, at 1:22 PM, observation revealed the reserved sidewall sprinkler heads were located outside the fire sprinkler cabinet in the Riser Room of the facility. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on February 8, 2022.	K 351	A. The facility failed to provide sprinkler systems in accordance with the NFPA 13 Section 13.6.2.9.3. Reserved sidewall sprinkler heads were located outside the fire sprinkler cabinet in the Riser Room of the facility. B. The potential exists to affect 68 residents. C. This facility has taken measures to properly store reserved sidewall sprinkler heads in the fire sprinkler cabinet in the Riser Room of the facility in accordance with the NFPA 13 Section 13.6.2.9.3. D. The Maintenance Staff and Administrator will conduct weekly rounds for four (4) weeks, then monthly rounds for three (3) months to ensure reserved sidewall sprinkler heads are stored properly in the fire sprinkler cabinet in the Riser Room of the facility in accordance with the NFPA 13 Section 13.6.2.9.3.starting on 3-21-2022. Starting on 4-2-2022, results of the above	

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K 351	Continued From page 7	K 351	listed rounds and any necessary corrective action taken will be reviewed in the weekly Quality Assurance meetings by the Quality Assurance Performance Improvement Committee. Necessary changes will be made to maintain sustained compliance.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to meet Standard for the inspection, Testing, and Maintenance of Water-Based Fire Protection System Components as required by NFPA 25 section 5.2.2.2. This deficient practice had potential to affect the entire facility on day of survey.	K 353	A. The facility failed to meet Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection System Components as required by NFPA 25 section 5.2.2.2. Observation revealed a red wire (to the fire alarm system) was zip tied to the metal sprinkler pipe in the	3/24/22

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K 353	Continued From page 8 Findings Include: On February 8, 2022, at 11:20 AM, observation revealed a red wire (to fire alarm system) was zip tied to the metal sprinkler pipe in the Kitchen of the facility. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on February 8, 2022.	K 353	Kitchen of the facility. B. The potential exists to affect 68 residents. C. This facility has taken measures to protect wiring to the fire alarm system. Wiring will be ran through approved conduit In accordance to NFPA 25 section 5.2.2.2. D. The Maintenance Staff and Administrator will conduct weekly rounds for four (4) weeks, then monthly rounds for three (3) months to ensure no wires are exposed in the Kitchen of the facility in accordance with the NFPA 13 Section 13.6.2.9.3.starting on 3-21-2022. Starting on 4-2-2022, results of the above listed rounds and any necessary corrective action taken will be reviewed in the weekly Quality Assurance meetings by the Quality Assurance Performance Improvement Committee. Necessary changes will be made to maintain sustained compliance.	
K 355 SS=D	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, the facility failed to	K 355	A. The facility failed to provide the fire	3/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255126	A. BUILDING **01 - BUILDING 0101** B. WING _____	**02/08/2022**

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K 355	Continued From page 9 provide the fire extinguisher in accordance with NFPA 101 section 19.3.5.12, NFPA 10. This deficiency affected one (1) of six (6) smoke compartments and seven (7) of 68 residents in the facility on the day of survey. Findings Include: On February 8, 2022, at 11:30 AM, observation reveal fire extinguishers were improperly installed at height of 6 feet in the following areas of the facility: 1. Beauty Shop 2. Laundry Room These fire extinguishers shall be installed no more than five (5) feet above the floor. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on February 8, 2022.	K 355	extinguisher in accordance with NFPA 101 section 19.3.5.12, NFPA 10. Observation revealed fire extinguishers were improperly revealed fire extinguishers were improperly installed at height of 6 feet in the following areas of the facility: 1. Beauty Shop 2. Laundry Room B. The potential exists to affect 68 residents. C. This facility has taken measures to provide fire extinguishers at proper height of 44 inches in accordance with NFPA 101 section 19.3.5.12, NFPA 10. D. The Maintenance Staff and Administrator will conduct weekly rounds for four (4) weeks, then monthly rounds for three (3) months to ensure fire extinguishers are at proper height of 44 inches in accordance with NFPA 101 section 19.3.5.12, NFPA 10 .starting on 3-21-2022. Starting on 4-2-2022, results of the above listed rounds and any necessary corrective action taken will be reviewed in the weekly Quality Assurance meetings by the Quality Assurance Performance Improvement Committee. Necessary changes will be made to maintain sustained compliance.	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier	K 372		3/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255126	A. BUILDING **01 - BUILDING 0101** B. WING _____	**02/08/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKINSON COUNTY SENIOR CARE	**116 SOUTH LAFAYETTE STREET** **CENTREVILLE, MS 39631**

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K 372	Continued From page 10 Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations the facility failed to provide the required 30-minute fire resistance rating for smoke barrier walls in accordance with NFPA 101 sections 19.3.7.3, 8.5, 8.5.6. This deficiency affected two (2) of the six (6) compartments and 27 of 68 residents in the facility on day of survey. On February 8, 2022, at 1:10 PM, observation revealed open, unsealed penetrations around wires in smoke barrier walls near Room 4 on the A Hall of the facility. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on February 8, 2022.	K 372	A. The facility failed to provide the required 30 □ minute fire resistance rating for smoke barrier walls in accordance with NFPA 101 sections 19.3.7.3, 8.5, 8.5.6. Observation revealed open un-sealed penetrations around wires in smoke barrier walls near room 4 on A Hall of the facility. B. The potential exists to affect 68 residents. C. This facility has taken measures to provide the required 30 □ minute fire resistance rating for smoke barrier walls in accordance with NFPA 101 sections 19.3.7.3, 8.5, 8.5.6. On 2-8-2022, Maintenance Staff applied the required fire rated caulk to the open penetration smoke barrier walls near room 4 on A Hall of the facility. D. The Maintenance Staff will work with any and all contractors during the final	

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	255126	A. BUILDING **01 - BUILDING 0101** B. WING _____	**02/08/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKINSON COUNTY SENIOR CARE	**116 SOUTH LAFAYETTE STREET** **CENTREVILLE, MS 39631**

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K 372	Continued From page 11	K 372	phase of any work that requires penetrations to Smoke Barriers, and insure the required fire caulk is applied to seal the Smoke Barrier wall. Starting on 4-2-2022, results of the above listed rounds and any necessary corrective action taken will be reviewed in the weekly Quality Assurance meetings by the Quality Assurance Performance Improvement Committee. Necessary changes will be made to maintain sustained compliance.	
K 711 SS=D	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to properly update the fire plan in accordance with NFPA 101 section 19.7.1.1 to 19.7.1.3, and 19.7.2.3. This deficiency had the potential to affect all 68 of the residents in the facility at the time of survey.	K 711	A. The facility failed to properly update the fire plan in accordance with NFPA 101 section 19.7.1.1 to 19.7.1.3. Observation revealed the fire plan did not include the facility/staff manually calling the fire department when the fire alarm was activated.	3/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255126	A. BUILDING **01 - BUILDING 0101** B. WING _____	**02/08/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKINSON COUNTY SENIOR CARE	**116 SOUTH LAFAYETTE STREET** **CENTREVILLE, MS 39631**

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K 711	Continued From page 12 Findings Include: On February 8, 2022, at 11:35 AM, document review revealed the fire plan did not include the facility/staff manually calling the fire department when the fire alarm was activated. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on February 8, 2022.	K 711	B. The potential exists to affect 68 residents. C. This facility has taken measures to update the fire plan to include direction for facility/staff to manually call the fire department to ensure the fire department has received notification of an alarm in the event of a fire at the facility. The Administrator has in-serviced all staff on this policy change. D. The Administrator will ensure the addendum to the Wilkinson County Senior Care Fire Policy is present in all policy manuals and the facility□s Emergency Operations Plan beginning on 3-31-2022. Annual update of the Emergency Operations Plan will include review of this policy addendum. Any corrective action will be reviewed in the weekly Quality Assurance meetings by the Quality Assurance Performance Improvement Committee. Necessary changes will be made to maintain sustained compliance.	
K 751 SS=D	Draperies, Curtains, and Loosely Hanging Fabr CFR(s): NFPA 101 Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48	K 751		3/24/22

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K 751	Continued From page 13 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1 This REQUIREMENT is not met as evidenced by: Based on interviews, the facility failed to provide documentation for draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with NFPA 101 sections 19.7.5.1 and 10.3.1. This deficiency had the potential to affect nine (9) of 68 residents in the facility at the time of survey. Findings include: On February 8, 2022, at 2:00 PM, interviews with the Administrator and Maintenance Supervisor revealed the facility did not have documentation showing the flame spread rating of the plastic used to seal off the Covid area of the facility. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on February 8, 2022	K 751	A. The facility failed to provide documentation for draperies, curtains including cubicle curtains and loosely hanging fabric or films in accordance with NFPA 101 sections 19.7.5.1 and 10.3.1. Observation revealed the facility did not have documentation showing the flame spread rating of the plastic used to seal off the Covid area of the facility. B. The potential exists to affect 9 of 68 residents. C. On 2-8-2022, maintenance staff removed the plastic used to seal off the Covid area of the facility for which documentation showing the flame spread rating of the plastic was not available. Any new material used in the facility will include documentation showing the flame spread rating of the material. D. The Maintenance Supervisor will obtain documentation showing the flame spread rating of the material used in the facility. For any new materials used in the facility, The Maintenance Supervisor will bring documentation showing the flame spread rating to be reviewed in the weekly Quality Assurance meetings by the Quality Assurance Performance Improvement Committee. Necessary changes will be made to maintain sustained compliance.	

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K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced	K 923		3/24/22

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K 923	Continued From page 15 by: Based on observations, the facility failed to properly store cylinders in accordance NFPA 99 sections 11.3.2. This deficiency affected one (1) of six (6) smoke compartments and 20 of 68 residents in the facility on day of survey. Findings Include On February 8, 2022, at 9:45 AM, observation revealed two (2) unsecured, oxygen bottles stored in the supply closet behind the Nurse Station A of the facility. The two (2) oxygen bottles were stored unproved area of the facility. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on February 8, 2022.	K 923	A. The facility failed to properly store cylinders in accordance to NFPA 99 Sections 11.3.2. Observation revealed two (2) unsecured, oxygen bottles stored in the supply closet behind the Nurses Station A of the facility. Maintenance Staff immediately secured the unsecured oxygen bottles to be stored in accordance to NFPA 99 Sections 11.3.2. B. The potential exists to affect 20 of 68 residents. C. On 3-16-2022, The Administrator in-serviced all facility staff to properly secure the oxygen bottles when entering and exiting the storage area. D. The Maintenance Staff and Administrator will conduct weekly rounds for four (4) weeks, then monthly rounds for three (3) months to ensure the oxygen bottles are properly stored beginning 3-21-2022. Starting on 4-2-2022, results of the above listed rounds and any necessary corrective action taken will be reviewed in the weekly Quality Assurance meetings by the Quality Assurance Performance Improvement Committee. Necessary changes will be made to maintain sustained compliance.	
K 925 SS=D	Gas Equipment - Respiratory Therapy Sources CFR(s): NFPA 101 Gas Equipment - Respiratory Therapy Sources of Ignition	K 925		3/24/22

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K 925	Continued From page 16 Smoking materials are removed from patients receiving respiratory therapy. When a nasal cannula is delivering oxygen outside of a patient's room, no sources of ignition are within in the site of intentional expulsion (1-foot). When other oxygen deliver equipment is used or oxygen is delivered inside a patient's room, no sources of ignition are within the area are of administration (15-feet). Solid fuel-burning appliances is not in the area of administration. Nonmedical appliances with hot surfaces or sparking mechanisms are not within oxygen-delivery equipment or site of intentional expulsion. 11.5.1.1, TIA 12-6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to properly update policy of oxygen plan in accordance with NFPA 99 section 11.5.1.1. This deficiency had the potential to affect all 68 of the residents in the facility at the time of survey. Findings include: On February 8, 2022, at 1:40 PM, document review revealed the oxygen plan did not address policy and procedure for the usage oxygen cylinder in the beauty shop. Observation revealed the beauty shop contain heat producing devices (ex. Hair dryer ...). The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on February 8, 2022.	K 925	A. The facility failed to properly update policy of oxygen plan in accordance with NFPA 99 section 11.5.1.1. B. The potential exists to affect 68 residents. C. This facility has taken measures to update the policy of oxygen plan in accordance with NFPA 99 section 11.5.1.1The Administrator has in-serviced all staff on this policy change. D. The Administrator will ensure the addendum to the Wilkinson County Senior Care Oxygen Safety Policy is present in all policy manuals beginning on 3-31-2022. Any corrective action will be reviewed in the weekly Quality Assurance meetings by the Quality Assurance Performance Improvement Committee. Necessary changes will be made to maintain sustained compliance.	

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