STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255331	A. BUILDING **01 - ARRINGTON LIVING CENTER** B. WING _____	**09/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARRINGTON LIVING CENTER	**701 SOUTH HOLLY STREET COLLINS, MS 39428**

(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 42 CFR 483.70(a) 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 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to provide 20-minute fire resistance rating smoke barrier door in accordance with NFPA 101 sections 19.3.7.6, 19.3.7.8, and 19.3.7.9. This standard deficiency affected entire facility on day of survey. On 9/13/2022 at 10:30 AM, observation revealed the 100 Hall smoke barrier wall doors of the facility did not properly close and latch upon activation of the fire alarm and sprinkler systems.	K 374	1. Immediate Action Taken for the Residents found to have been affected " Arrington Living Center contacted B & E Communications on Tuesday, September 13, the day of Life Safety survey, to repair issue with 100 Hall smoke barrier wall doors. Repairs were completed on Tuesday, September 13. The door release relay had malfunctioned and was replaced.	9/14/22

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

Electronically Signed | 09/29/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255331	A. BUILDING **01 - ARRINGTON LIVING CENTER** B. WING _____	**09/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARRINGTON LIVING CENTER	**701 SOUTH HOLLY STREET** **COLLINS, MS 39428**

(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 374	Continued From page 1 The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor during the exit interview.	K 374	2. Identification of other residents having the potential to be affected was accomplished by: " All residents had the potential to be affected by the smoke barrier wall doors of 100 Hall not closing properly. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: " The Fire Drill evaluation form was updated on September 29, 2022, to include verification of smoke barrier doors release. (see attached) " The Fire Doors Inspection form was updated on September 29, 2022, to include verification of release and hold of smoke barrier doors. (see attached) 4. How corrective action will be monitored to ensure the practice will not occur. Monitoring of the smoke barrier wall doors was added to the fire drill reports. Facility will continue to monitor the fire doors monthly to ensure proper function and report on the Fire Door Inspection form. 5. Indicate the date(s) the corrective action(s) will be completed. The corrective action was completed on September 14, 2022.	