STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155469	A. BUILDING -- B. WING	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/16/23 Facility Number: 000366 Provider Number: 155469 AIM Number: 100288900 At this Emergency Preparedness survey, Casa of Hobart was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 138 certified beds. At the time of the survey, the census was 94. Quality Review completed on 11/20/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/16/23 Facility Number: 000366 Provider Number: 155469 AIM Number: 100288900 At this Life Safety Code survey, Casa of Hobart was found not in compliance with Requirements	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Angela Pazera	12/07/2023	12/07/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility was surveyed as three separate buildings due to the construction types of three sections of the building: Building 0102 originally built in 1951 as a house is of Type V (000) construction and is fully sprinklered; Building 0202 renovated in 1972 and 1999 was determined to be of Type II (111) construction and is now sprinklered; and Building 0302 built in 1999 was determined to be of Type V (111) construction and fully sprinklered, encompasses the north and southeast sections of the facility. The facility has one fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 138 and a census of 94 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 11/20/23			
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited			

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	cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			
	Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen fire suppression system was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices. Hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect staff in the kitchen and 15 residents in the adjacent dining room. Findings include: Based on records review with the Maintenance Director and VP of Operations on 11/16/23 between 09:24 a.m. and 11:35 a.m., the only documentation of semiannual kitchen suppression system inspection available for review was dated 07/17/23. An inspection six months before	K 0324	p paraid="1086561185" paraeid="{52a9a844-b1cc-4b6d-87da-0e9b709422bf}{5}" >K324 NFPA 101 COOKING FACILITIES The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of	12/08/2023

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	07/17/23 was not conducted. Based on interview at the time of record review, the VP of Operations stated that the kitchen at the beginning of the year was not in use due to issues with remodeling in which the kitchen suppression system was not inspected. Findings were discussed with the VP of Operations, Maintenance Director and Administrator at exit conference. 3.1-19(b)		deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: Kitchen Fire Suppression System Inspection is current and in compliance. 2) How the facility identified other residents: Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. 3) Measures put into place/ System changes: p paraid="1213536152" paraeid="{52a9a844-b1cc-4b6d-87da-0e9b709422bf}{111}" >	

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			The Maintenance Director or Designee will review preventative maintenance schedule to ensure vendors are scheduled to complete inspections in a timely manner. The Maintenance Director will the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator /designee by 11/24/23. ·The Maintenance Director is responsible for compliance. 4)How the corrective actions will be monitored: The Administrator will review the Preventative Maintenance Worksheets monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved.¿ The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as	

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			indicated. 5)Date of compliance: 12-8-2023	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation of the fire alarm control panel on 11/16/23 at 1:40 p.m. during a tour of the facility with the Maintenance Director, the time on the fire alarm control panel was incorrect. The display on the main fire alarm control panel indicated the date and time to be 11/16/23 at 19:58:22 p.m. Based on interview at the time of observation, the Maintenance Director indicated	K 0345	K345 NFPA 101 Fire Alarm System- Testing and Maintenance The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. p="" paraid="656284264" paraeid="{52a9a844-b1cc-4b6d-87da-0e9b709422bf} {240}"> Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it	12/08/2023

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	he was unaware of the discrepancy and would contact the alarm company to have the displayed time updated on the fire alarm control panel. This finding was reviewed with the Maintenance Director, VP of Operations and Administrator at the exit conference. 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice affects all occupants in the facility. Findings include: During records review with the Maintenance Director and VP of Operations on 11/16/23 between 09:24 a.m. and 11:35 a.m., no documentation was provided regarding a visual inspection of the fire alarm system six months prior to the annual fire alarm inspection conducted on 09/7/23. Based on interview at the time of records review, the VP of Operations stated that no documentation could be found that would confirm if an inspection had been done.		is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: Fire Alarm System visual inspection completed. Fire Alarm control panel time and date information corrected. 2) How the facility identified other residents: Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. 3) Measures put into place/ System changes: The Maintenance Director or Designee will complete visual annually of Fire Alarm System and will document on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator /designee by 11/24/23. The Maintenance Director is responsible for compliance. 4)How the corrective actions will be monitored: ul="" role="list" The Administrator will review the Preventative Maintenance Worksheets monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved.¿ The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5)Date of compliance:	

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	This finding was reviewed with the Maintenance Director, VP of Operations and Administrator at the exit conference. 3.1-19(b)		12/8/23	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation 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 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) 1. Based on observation and interview, the facility failed to provide an automatic sprinkler system that provided complete coverage in 1 of 5 smoke compartments. This deficient practice could affect approximately 15 residents and staff. Findings include: Based on observation on 11/16/23 between 11:56	K 0351	K351 NFPA 101 Sprinkler System- Installation The facility requests paper compliance for this citation.	12/08/2023

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	a.m. and 1:26 p.m. during a tour of the facility with the VP of Operations and Maintenance Director, the walk-in freezer located in the kitchen had no sprinkler coverage inside. Based on interview at the time of observation, the Maintenance Director stated that the freezer had been installed approximately a month ago. He further stated that the sprinkler company has been scheduled to complete the sprinkler head addition and should be there within the week and had an email confirming the work is to be done, but agreed the freezer was lacking sprinkler coverage at the time of the survey. This finding was reviewed with the Administrator, VP of Operations and Maintenance Director at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 6 smoke compartments in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect approximately 15 residents and staff. Findings include: Based on observations during a tour of the facility with the Maintenance Director and VP of Operations on 11/16/23 between 11:56 a.m. and 1:26 p.m., in the corner of the kitchen by the dining room entrance was a sprinkler head that was missing an escutcheon plate. The space between the sprinkler head and the ceiling left an		This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: p paraid="132707328" paraeid="{a00c0357-cd02-432c-b71b-db89aec4b1e5}{233}" > Sprinkler head escutcheon was installed. ·Sprinkler head between Freezer and Cooler properly installed. ·Walk-in Freezer sprinkler installation completed.	

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	approximately one-half inch gap. Furthermore, the sprinkler head between the freezer and cooler had an escutcheon plate attached, however it was dislodged and left an approximately one-quarter inch gap between the sprinkler head and ceiling. Based on interview at the time of observation, the Maintenance Director confirmed the annular space between the two sprinkler heads and stated he would have the sprinkler company fix the aforementioned issues. Findings were discussed with the Maintenance Director, VP of Operations and Administrator at exit conference. 3.1-19(b)		2) How the facility identified other residents: Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. 3) Measures put into place/ System changes: The Maintenance Director or Designee will complete monthly visual inspection of Sprinkler Heads and will document it on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator /designee by 11/24/23. The Maintenance Director is responsible for compliance. 4)How the corrective actions will be monitored:	

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			The Administrator will review the Preventative Maintenance Worksheets monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved.¿ The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5)Date of compliance: 12/8/23	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 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 _____			

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	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 1. Based on record review and interview, the facility failed to maintain 1 of 2 automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents and staff. Findings include: Based on records review of the annual fire sprinkler inspection titled "Report of Inspection/Test" documentation dated 07/27/23 with Maintenance Director and VP of Operations on 11/16/23 between 09:24 a.m. to 1:26 p.m., listed in the deficiency list on page 12, the sprinkler report indicated that the dry sprinkler system failed its air leakage test. No documentation was located during the survey to indicate whether the sprinkler system had been repaired. Based on interview at the time of record review, the	K 0353	p paraid="2137410054" paraeid="{ae191572-2059-4813-bc31-8dac20c4b4f5}{148}" >K353 NFPA 101 Sprinkler System-Maintenance and Testing The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	12/08/2023

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	Maintenance Director stated that there was miscommunication between the sprinkler company and the facility and had never received a quote to fix the sprinkler system. Findings were discussed with the Maintenance Director, VP of Operations and Administrator at exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 2 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility.		1)Immediate actions taken for those residents identified: Dry Sprinkler air leakage repaired. ·Sprinkler Quarterly inspection is current and in compliance. ·Monthly/weekly inspection of wet and dry pipes sprinkler system's gauges and valves are current and in compliance. 2) How the facility identified other residents: Staff, Visitors, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. p paraid="924794844" paraeid="{66d3b976-ee5a-4e2d-9dc9-5cfe45793d13}{11}" > 3) Measures put into place/ System changes:	

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	155469	A. BUILDING 01 B. WING	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Findings include: Based on review of the quarterly sprinkler system inspection records with the Maintenance Director and VP of Operations on 11/16/23 between 09:24 a.m. and 11:35 a.m., there was no quarterly sprinkler system inspection report available for the second quarter (April, May, and June) and first quarter (January, February, and March) of 2023. During an interview at the time of record review, the VP of Operations acknowledged there was no written documentation available to show the sprinkler system had been inspected during the second and first quarter of 2023. Furthermore, she went on to state that there were issues with the sprinkler system at that time and inspections were could have been missed. Findings were discussed with the Maintenance Director, VP of Operations and Administrator at exit conference. 3.1-19(b) 3. Based on record review and interview, the facility failed to maintain 2 of 2 sprinkler systems in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or		The Maintenance Director or Designee will complete monthly visual inspection of Sprinkler Heads and monthly inspection of the wet pipe system to include gauges and valves. Inspections will document it on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator /designee by 11/24/23. The Maintenance Director is responsible for compliance. 4)How the corrective actions will be monitored: The Administrator will review the Preventative Maintenance Worksheets monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved.¿ The QA Committee will identify any trends or patterns and make recommendations to revise	

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	valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and VP of Operations on 11/16/23 between 09:24 a.m. and 11:35 a.m., there were no monthly or weekly inspections of the wet and dry pipe sprinkler system's gauges and valves for the months of December 2022 to February 2023. During an interview at the time of record review, the VP of Operations stated the inspection of gauges and valves were missed due to continuing maintenance on the sprinkler system and had been missed during those time periods. Findings were discussed with the Maintenance Director, VP of Operations and Administrator at exit conference. 3.1-19(b)		the plan of correction as indicated. 5)Date of compliance: 12/8/2023	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors 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			

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	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 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.			
	Based on observation and interview, the facility failed to ensure 1 of 1 door to the corridor would completely resist the passage of smoke. 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. This deficient practice could affect approximately 10 residents, as well as staff and visitors. Findings include:	K 0363	K363 NFPA 101 Corridor- Doors The facility requests paper compliance for this citation. p paraid="1993607932" paraeid="{66d3b976-ee5a-4e2d-9dc9-5cfe45793d13}{159}" >This Plan of Correction is the center's	12/08/2023

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	Based on observation on 11/16/23 between 11:56 a.m. and 1:26 p.m. during a tour of the facility with the VP of Operations, the door to the physical therapy gym leading to the main lobby had an approximate one inch circular shaped hole next the handle to the door that opened to the corridor. Based on interview at the time of observation, the VP of Operations confirmed the door penetration and stated the hole will be repaired. Findings were discussed with the Maintenance Director, VP of Operations and Administrator during the exit conference. 3.1-19(b)		credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: Physical Therapy room door penetration corrected to preserve door integrity. 2) How the facility identified other residents: Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice.	

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			3) Measures put into place/ System changes: The Maintenance Director or Designee will complete monthly visual inspection of doors to ensure there are no penetrations and will document it on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator /designee by 11/24/23. The Maintenance Director is responsible for compliance. 4)How the corrective actions will be monitored: ul class="BulletListStyle1 SCXW217331064 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;"	

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			The Administrator will review the Preventative Maintenance Worksheets monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved.¿ The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5)Date of compliance: 12/8/23	