STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	154011	A. BUILDING -- B. WING	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INCOMPASS HEALTHCARE	285 BIELBY RD LAWRENCEBURG, IN 47025

(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 482.15. Survey Date: 05/19/25 - 05/20/25 Facility Number: 005176 Provider Number: 154011 AIM Number: 200147890A At this Emergency Preparedness survey, Community Mental Health Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 482.15 The facility has 16 certified beds. At the time of the survey, the census was 11. Quality Review completed on 05/28/25	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 482.41(b). Survey Date: 05/19/25 - 05/20/25 Facility Number: 005176 Provider Number: 154011 AIM Number: 200147890A At this Life Safety Code survey, Community Mental Health Center was found not in	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Heather Scott	Director of Quality	06/16/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154011	A. BUILDING 01 B. WING	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INCOMPASS HEALTHCARE	285 BIELBY RD LAWRENCEBURG, IN 47025

(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
	compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 482.41(b), 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. The Community Mental Health Center was located on the non-sprinklered first floor, East Wing, of a three story, partially sprinklered hospital with a basement of Type I (332) construction. There is a 2 hour fire separation wall between the hospital and the Community Mental Health Center. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard-wired smoke detectors in all patient sleeping rooms. The facility has a capacity of 16 and had a census of 11 at the time of this survey. Quality Review completed on 05/28/25			
K 0222 Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through the double door set in the crisis stabilization unit was readily accessible for clients without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 15, staff and visitors if needing to exit the facility. Findings include:	K 0222	p="" xml: paraid="19907670" paraeid="{eb90f1fa-bc1e-4306-8bf6-d486ef444125}{112}">Corrective Action Plan: Egress Accessibility Deficiency (Crisis Stabilization Unit) Person Responsible: Facilities Maintenance Manager **1. Short – term Correction:** *Restore Unobstructed Egress Functionality*- Reconfigure or replace door hardware to allow free and unobstructed egress from both sides without the use of a badge, key, or tool, in accordance	08/31/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154011	A. BUILDING 01 B. WING	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INCOMPASS HEALTHCARE	285 BIELBY RD LAWRENCEBURG, IN 47025

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	Based on observations and interviews during a tour of the facility with the Safety and Security Coordinator (SSC) and Director of Quality Improvement (DOQ) on 05/19/25 at 3:30 p.m. the double doors separating the Full Crisis Unit from the Mobil Crisis Unit, marked from each side as a facility exit, was magnetically locked and could be opened with panic hardware from the Mobil Crisis side. However, the doors could only be opened from the Full Crisis side without the use of a badge or special key. The aforementioned doors were not connected to the hospital's fire alarm system and this part of the facility did not have a fire alarm system. The DOQ stated the arrangement with the doors was added during a recent remodel/refresh of this part of the facility. This finding was acknowledged by the SSC and DOQ at the time of observation and again at the exit conference with the SSC and DOQ each present.		with LSC 19.2.2.2.4. - Short-term: Delayed egress on locked double doors (15 second delay) - Ensure egress is functional on both sides of the double door set. - Anticipated Completion: 6/30/2025**2. Long – Term Correction:** *Integrate Doors with Fire Alarm System*- Install or upgrade the fire alarm system in the Full Crisis Unit to meet NFPA 101 and NFPA 72 standards. - Ensure the magnetic locking system disengages automatically upon fire alarm activation. - Anticipated Completion: 8/31/2025**3. Review and Update Life Safety Plans:** - Modify facility egress diagrams, life safety drawings, and EPP to reflect corrected hardware and fire system connectivity. - Re-verify exit signage to ensure it accurately reflects accessible egress routes. **4. Staff Training and Documentation:** - Conduct re- Crisis Care Center and Mobile Crisis staff on proper egress protocols and emergency evacuation procedures. - Maintain documentation of hardware modifications, system integration, and staff training for compliance review.**5. Future Renovation Controls:** Implement review procedures to ensure any future remodels that affect egress routes are vetted through Life Safety Code compliance checks before implementation.	

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			Additionally, the Facilities Maintenance Manager has reached out to Maxwell Construction who completed the renovation of the Crisis Care Center where the double doors are located to determine if this space is applicable to any waiver or exemption. As of 6/16/2025 at 5:30PM INcompass had not received a response from Maxwell Construction. Important to note the long-term correction may change based on the response from Maxwell Construction and what is most feasible (time-frame and fiscally) for the space to create the appropriate egress.	
K 0000 Bldg. 02	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 482.41(b). Survey Date: 05/19/25 - 05/20/25 Facility Number: 005176 Provider Number: 154011 AIM Number: 200147890A At this Life Safety Code survey, Community Mental Health Center In Patient unit was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 482.41(b), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC),	K 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154011	A. BUILDING 02 B. WING	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INCOMPASS HEALTHCARE	285 BIELBY RD LAWRENCEBURG, IN 47025

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	Chapter 19, Existing Health Care Occupancies. The In Patient Center was located on the non sprinklered first floor, East Wing, of a three story, partially sprinklered hospital with a basement of Type I (332) construction. There is a 2 hour fire separation wall between the hospital and the Community Mental Health Center. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all patient sleeping rooms. The facility has a capacity of 16 and had a census of 11 at the time of this survey. Quality Review completed on 05/28/25			
K 0321 Bldg. 02	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of over 3 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 5 residents, as well as staff and visitors in the near the nurse's office area. Findings include: Based on the facility tour and interview with the Safety and Security Coordinator (SSC) and Facilities Maintenance Manager (FMM) on 05/19/25 at 3:45 p.m., an office/room the facility was using as the nurse's station was greater than 50 square feet and contained a number of combustible items, such as, paper, and over 8 large cardboard boxes. The corridor door to this office/room/nurse's station was not equipped with a self-closing device and did not self-close and latch into the door frame.	K 0321	**Corrective Action Plan: Hazardous Area Door (Nurse's Station)** **Person Responsible: Facilities Maintenance Manager** **1.Install a Self-Closing Device:** **·Equip the identified door with a code-compliant self-closing and latching device.** **·Ensure the door closes fully and latches securely into the frame on each operation.** **2.Remove and Properly Store Combustible Materials:** **·Relocate excess combustible items (e.g., cardboard boxes, paper) to designated storage rooms that meet LSC requirements.**	06/30/2025

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	This finding was acknowledged by the SSC and FMM at the time of observation and again at the exit conference with the SSC and Director of Quality present.		**·Maintain clinical function of nurse's station(NS) by limiting storage in the NS to essential, non-combustible materials where feasible.** **·Items corrected: 6/13/2025** **3.Update Staff Training and Maintenance Checks:** **·Educate nursing and facilities staff on the importance of maintaining clutter free spaces and proper storage procedures** **4.Document Corrective Measures:** **·Keep records of hardware installation, compliance checks, and training as part of Life Safety documentation for compliance review.**	
K 0345 Bldg. 02	NFPA 101 Fire Alarm System - Testing and Maintenance 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.)	K 0345	**Corrective Action – Fire Alarm System Semi-Annual Visual Inspections** **Person Responsible: Facilities Maintenance Manager** **1.Initiate Semi-Annual Inspections**: ·Immediately schedule semi-annual visual inspections of all applicable fire alarm components as per NFPA 72, Section 14.3.1 and Table 14.3.1. ·This section of the facility is maintained by St Elizabeth Hospital - Hospital Facilities Team	07/31/2025

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	d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: Based on records review and interview with the Safety and Security Coordinator (SSC) and Hospitals Facilities Maintenance Manager on 05/19/25 at 1:30 p.m. no documentation could be provided regarding a visual semi-annual fire alarm system inspection. The Hospitals Maintenance Manager stated that the facility was not aware of the 6-month visual inspection requirement. The In-Patient Center is located in a portion of the building where the fire alarm system is maintained by the hospital. The hospital staff stated that they would need to get a points list developed and a semiannual inspection scheduled in their Computer Maintenance Monitoring System. This finding was acknowledged by the SSC at the time of observation and again at the exit conference with the SSC and Director of Quality present.		has indicated that they complete the annual visual components inspection as required in NFPA 72 2010 Table 14.3.1. ·Utilize qualified personnel or a certified fire alarm service provider to conduct the inspections. ·Inspection Requested: To be completed by 6/30/2025 **2.Develop a Fire Alarm Inspection Points List**: ·Coordinating with the hospital facilities team (St. Elizabeth) to create a comprehensive inspection points list that includes all devices and equipment requiring semi-annual visual checks. St Elizabeth has indicated that it will be completed 6/20/2025 and provided to INcompass. **3.Implement Tracking**: ·Establish a compliance tracking system (e.g., calendar reminders, logbook, or digital maintenance software) to ensure timely inspections and proper recordkeeping. ·Facilities Maintenance Manager will ensure escalation procedures are in place for any missed or delayed inspections. **4.Document and File Inspection Reports**: ·Maintain clear and accessible documentation of each inspection, including: ·Inspection date ·Items inspected	

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			·Inspector's name or company ·Any deficiencies noted and corrective actions taken **5.Audit and Compliance Review**: ·Updated internal audit checklist two include semi-annual fire alarm visual inspections (previously annual). ·Ongoing: Review inspection records quarterly to ensure ongoing compliance (Safety & Security Coordinator).	
K 0000 Bldg. 03	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 482.41(b). Survey Date: 05/19/25 - 05/20/25 Facility Number: 005176 Provider Number: 154011 AIM Number: 200147890A At this Life Safety Code survey, Community Mental Health Center IDDT Unity House was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 482.41(b), 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. The IDDT Unity House was located above the In Patient unit on the sprinklered second floor, East Wing, of a three story, partially sprinklered	K 0000		

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	154011	A. BUILDING 03 B. WING	05/20/2025

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INCOMPASS HEALTHCARE	285 BIELBY RD LAWRENCEBURG, IN 47025

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	hospital with a basement of Type I (332) construction. There is a 2 hour fire separation wall between the hospital and the Community Mental Health Center. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all patient sleeping rooms. The facility has a capacity of 16 and had a census of 11 at the time of this survey. Quality Review completed on 05/28/25			
K 0345 Bldg. 03	NFPA 101 Fire Alarm System - Testing and Maintenance 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 could affect all building occupants. Findings include: Based on records review and interview with the Safety and Security Coordinator (SSC) and Hospitals Facilities Maintenance Manager on	K 0345	**Corrective Action – Fire Alarm System Semi-Annual Visual Inspections** **Person Responsible: Facilities Maintenance Manager** **1.Initiate Semi-Annual Inspections**: ·Immediately schedule semi-annual visual inspections of all applicable fire alarm components as per NFPA 72, Section 14.3.1 and Table 14.3.1. ·This section of the facility is maintained by St Elizabeth Hospital - Hospital Facilities Team has indicated that they complete the annual visual components inspection as required in NFPA 72 2010 Table 14.3.1. ·Utilize qualified personnel or a certified fire alarm service provider to conduct the inspections. ·Inspection Requested: To be completed by 6/30/2025	07/31/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	05/19/25 at 1:30 p.m. no documentation could be provided regarding a visual semi-annual fire alarm system inspection. The Hospitals Maintenance Manager stated that the facility was not aware of the 6-month visual inspection requirement. The UNITY HOUSE is located in a portion of the building where the fire alarm system is maintained by the hospital. The hospital staff stated that they would need to get a points list developed and a semiannual inspection scheduled in their Computer Maintenance Monitoring System. This finding was acknowledged by the SSC at the time of observation and again at the exit conference with the SSC and Director of Quality present.		**2.Develop a Fire Alarm Inspection Points List**: ·Coordinating with the hospital facilities team (St. Elizabeth) to create a comprehensive inspection points list that includes all devices and equipment requiring semi-annual visual checks. St Elizabeth has indicated that it will be completed 6/20/2025 and provided to INcompass. **3.Implement Tracking**: ·Establish a compliance tracking system (e.g., calendar reminders, logbook, or digital maintenance software) to ensure timely inspections and proper recordkeeping. ·Facilities Maintenance Manager will ensure escalation procedures are in place for any missed or delayed inspections. **4.Document and File Inspection Reports**: ·Maintain clear and accessible documentation of each inspection, including: ·Inspection date ·Items inspected ·Inspector's name or company ·Any deficiencies noted and corrective actions taken **5.Audit and Compliance Review**: ·Updated internal audit checklist two include semi-annual fire alarm visual inspections (previously annual).	

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			·Ongoing: Review inspection records quarterly to ensure ongoing compliance (Safety & Security Coordinator).	
K 0000 Bldg. 04	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 482.41(b). Survey Date: 05/19/25 - 05/20/25 Facility Number: 005176 Provider Number: 154011 AIM Number: 200147890A At this Life Safety Code survey, Community Mental Health Center 281 Building was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 482.41(b), 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. The 281 Building was separate from Main center located on the ground floor of a three story sprinklered building with a basement of Type III (222) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. This is an Administrative building. There are no resident rooms. Quality Review completed on 05/28/25	K 0000		
K 0345	NFPA 101 Fire Alarm System - Testing and			

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Bldg. 04	Maintenance 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 could affect all building occupants. Findings include: Based on records review and interview with the Safety and Security Coordinator (SSC) and Facilities Maintenance Manager (FMM) on 05/19/25 at 1:30 p.m. no documentation could be provided regarding a visual semi-annual fire alarm system inspection. The FMM stated that the facility was not aware of the 6-month visual inspection requirement. This facility is located in a portion of the campus where the fire alarm system is maintained by the facility. This finding was acknowledged by the SSC and FMM at the time of observation and again at the exit conference with the SSC and Director of Quality present.	K 0345	**Corrective Action – Fire Alarm System Semi-Annual Visual Inspections** **Person Responsible: Facilities Maintenance Manager** **1.Initiate Semi-Annual Inspections**: ·Immediately schedule semi-annual visual inspections of all applicable fire alarm components as per NFPA 72, Section 14.3.1 and Table 14.3.1. ·Utilize qualified personnel or a certified fire alarm service provider to conduct the inspections. ·Inspection Requested: To be completed by 6/30/2025 **2.Develop a Fire Alarm Inspection Points List**: ·Coordinating with the hospital facilities team (St. Elizabeth) to create a comprehensive inspection points list that includes all devices and equipment requiring semi-annual visual checks. St Elizabeth has indicated that it will be completed 6/20/2025 and provided to INcompass. **3.Implement Tracking**: ·Establish a compliance tracking system (e.g., calendar reminders, logbook, or digital maintenance software) to ensure timely inspections and proper recordkeeping. ·Facilities Maintenance Manager will ensure escalation	06/30/2025

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			procedures are in place for any missed or delayed inspections. **4.Document and File Inspection Reports**: ·Maintain clear and accessible documentation of each inspection, including: ·Inspection date ·Items inspected ·Inspector's name or company ·Any deficiencies noted and corrective actions taken **5.Audit and Compliance Review**: ·Updated internal audit checklist two include semi-annual fire alarm visual inspections (previously annual). ·Ongoing: Review inspection records quarterly to ensure ongoing compliance.	
K 0353 Bldg. 04	NFPA 101 Sprinkler System - Maintenance and Testing 1. 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 3 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	K 0353	**Corrective Action: Quarterly Sprinkler Checks** **Person Responsible: Safety & Security Coordinator** **·Re-establish quarterly sprinkler system inspections per NFPA 25, Sections 5.2.5 and 5.3.3.** **·Re-establish a compliance tracking system (e.g., calendar reminders, logbook, or digital maintenance software) to ensure timely inspections and proper recordkeeping.**	06/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154011	A. BUILDING 04 B. WING	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INCOMPASS HEALTHCARE	285 BIELBY RD LAWRENCEBURG, IN 47025

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	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. Findings include: Based on review of the quarterly sprinkler system inspection records with the Safety and Security Coordinator (SSC) and Facilities Maintenance Manager (FMM) on 05/19/25 at 3:15 p.m., only 1 (dated 06/13/24) of the required 4 quarterly sprinkler inspections was available for review. During an interview at the time of record review, the FMM acknowledged there was no written documentation available to show the sprinkler system had been inspected three of the four quarters stating that they had only had one inspection per year since he began working at the facility a few years ago. During a tour of the Riser Room on 05/20/25 at 10:05 a.m., hang tags from the sprinkler company indicated that only the aforementioned inspection was conducted. Previous hangtags from several years earlier revealed that once upon a time four quarterly inspections were conducted on the sprinkler system. The FMM stated he would contact the facility's sprinkler provider and begin 4 quarterly inspections immediately.		**·Ensure all inspection reports clearly state:** **·The procedure performed** **·The organization performing the work** **·The date and results** **·Inspection Scheduled: Requested to be completed by 6/30/2025** **·Safety & Security Coordinator will be responsible for these records and maintain them in a designated location readily available for compliance reviews.** **Corrective Action: Improper Storage of Spare Sprinklers and Missing Proper Cabinet Organization** **Person Responsible: Facility Maintenance Manager** **·An Extra sprinkler head cabinet was installed on 5/22 to store extra sprinkler heads found during inspection.** **·Staff educated on the proper storage standards for sprinkler components.** **·Safety & Security Coordinator will be responsible for these records and maintain them in a designated location readily available for compliance reviews.**	

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	2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on the facility tour and interview with the Safety and Security Coordinator (SSC) and Facilities Maintenance Manager (FMM) on 05/20/25 at 10:10 a.m., there was one spare sprinkler cabinet in the riser room that included in excess of 15 spare sprinklers; 7 or more of which were not in their own protected slot. They were stored loose in and on the cabinet and not secured in holders. Based on interview at the time of the observation, the FMM agreed the spare sprinkler cabinet had spare sprinklers not in protected slots. This finding was acknowledged by the SSC and FMM at the time of observation and again at the exit conference with the SSC and Director of			

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	Quality present.			