STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155215	A. BUILDING -- B. WING	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PLAINFIELD HEALTH CARE CENTER	3700 CLARKS CREEK RD PLAINFIELD, IN 46168

(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: 04/28/25 Facility Number: 000121 Provider Number: 155215 AIM Number: 100290940 At this Emergency Preparedness survey, Plainfield Health Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 189 certified beds. At the time of the survey, the census was 112. Quality Review completed on 05/01/25	E 0000	Preparation and submission of this plan of correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this survey. Accordingly, the facility has prepared and submits this plan of correction solely as a requirement under state and federal law that mandates a submission of a plan of correction as a condition to participate in Title 18 and 19 programs and to provide the best possible care to our residents as possible. The facility respectfully requests a desk review for this plan of correction.	
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: 04/28/25 Facility Number: 000121 Provider Number: 155215 AIM Number: 100290940 At this Life Safety Code survey, Plainfield Health	K 0000	Preparation and submission of this plan of correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this survey. Accordingly, the facility has prepared and submits this plan of correction solely as a requirement under state and federal law that mandates a submission of a plan of correction	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Burton	Administrator	05/30/2025

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	Care Center was found not in compliance with Requirements 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 two-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 189 and had a census of 112 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 05/01/25		as a condition to participate in Title 18 and 19 programs and to provide the best possible care to our residents as possible. The facility respectfully requests a desk review for this plan of correction.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through 2 of 7 exits were readily accessible for residents 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 as many as 24 residents, 6 staff and 3 visitors in the facility. Findings include:	K 0222	1--What corrective actions will be accomplished for those residents to have been affected by the deficient practice? The exit doors on the 200 hall nearest to the Riser room have had the code posted. 2--How are other residents having the potential to be affected by the same deficient practice be identified and what corrective action (s) will be taken?	05/19/2025

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	Based on observations made with the Maintenance Director and the visiting Maintenance Director during a tour of the facility on 04/28/25 at 12:40 p.m., the exit doors on the 200 Hall nearest to the Riser room were marked as a facility exit, were magnetically locked and could be opened by entering a four-digit code, but the code was not posted at the exit. Based on interview on 04/28/25 at 12:42 p.m., the Maintenance Director stated the aforementioned facility doors were indeed marked as an exit and could be opened by entering a four-digit code but affirmed that the code was not posted at that door set adding that he would have the code posed as soon as possible. This item was discussed at the exit conference with the Maintenance Director, the visiting Maintenance Director and the facility Administrator held on 04/28/25. 3.1-19(b)		The exit doors on the 200 hall nearest to the Riser room have had the code posted. 3--What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? Maintenance Director/designee will audit the exit doors to ensure the codes are posted on them. This will occur five times a week for 4 weeks and then weekly for 4 weeks. 4--How will the corrective actions be monitored to ensure the deficient practice will not reoccur? Audit results will be reviewed and reported to the IDT in QAPI. Determination of ongoing monitoring will be completed within the QAPI process.	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Based on record review and interview, the facility failed to ensure 5 of 5 battery backup lights were tested monthly for 30 seconds and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a	K 0291	1--What corrective actions will be accomplished for those residents to have been affected by the deficient practice? All five battery backup lights have been tested for both the 30 second test and the 90 minute test. 2--How are other residents having	05/19/2025

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	maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on record review on 04/28/25 at 11:07 a.m. with the Maintenance Director and the visiting Maintenance Director, the Battery-Operated Emergency Light Test Log for 2025 indicated five battery operated lights located throughout the facility, but the testing for March of 2025 had not been documented. Based on an interview on 04/28/25 at 11:08 a.m., the Maintenance Director indicated the facility did indeed have five battery operated emergency lights located throughout the facility, but the testing for those lights in March of 2025 was missed because this item was not listed in his TELS tasks to be completed. The lack of monthly testing of the five battery operated emergency lights in the month of March 2025 was acknowledged by the Maintenance Director who advised that he would call Direct Supply and add it to his "Tasks to do list" as soon as possible. This item was discussed at the exit conference with the Maintenance Director, the visiting Maintenance Director and the facility Administrator held on 04/28/25. 3.1-19(b)		the potential to be affected by the same deficient practice be identified and what corrective action (s) will be taken? All five battery backup lights have been tested for both the 30 second test and the 90 minute test. 3--What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? Both the 30 second monthly test and the 90 minute annual test will be placed on an audit tool that will be reviewed monthly to ensure compliance. 4--How will the corrective actions be monitored to ensure the deficient practice will not reoccur? Audit results will be reviewed and reported to the IDT in QAPI. Determination of ongoing monitoring will be completed within the QAPI process.	
K 0300 SS=F	NFPA 101 Protection - Other			

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Bldg. 01	Based on record review, interview and observation, the facility failed to ensure documentation for the preventative maintenance of 94 of 94 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 04/28/25 at 10:23 a.m. with the Maintenance Director and the visiting Maintenance Director, there was no itemized list of resident room battery operated smoke alarms tested for functionality for the month of March 2025. Based on interview on 04/28/25 at 10:25 a.m., the Maintenance Director acknowledged the battery-operated smoke detector manufacturer recommendations called for monthly testing with the last documented monthly inspection being completed on February 1st of 2025. The lack of monthly testing of the 94 battery operated smoke alarms in the month of March 2025 was acknowledged by the Maintenance Director who advised that he would call Direct Supply and add it to his "Tasks to do list" as soon as possible. Based on observations made between 12:35 p.m. and 3:02 p.m. during a tour of the facility, battery operated smoke alarms were observed in all	K 0300	1--What corrective actions will be accomplished for those residents to have been affected by the deficient practice? 94 battery operated smoke alarms have been documented for their monthly inspections. 2--How are other residents having the potential to be affected by the same deficient practice be identified and what corrective action (s) will be taken? 94 battery operated smoke alarms have been documented for their monthly inspections. 3--What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? The 94 battery operated smoke alarms Will be placed on an audit tool to ensure the monthly testing occurs. 4--How will the corrective actions be monitored to ensure the deficient practice will not reoccur? Audit results will be reviewed and reported to the IDT in QAPI. Determination of ongoing monitoring will be completed within the QAPI process.	05/19/2025

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	resident sleeping rooms. This item was discussed at the exit conference with the Maintenance Director, the visiting Maintenance Director and the facility Administrator held on 04/28/25. 3.1-19(b)			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure the corridor door to 1 of over 10 hazardous areas, such as combustible storage rooms over 50 square feet, soiled linen rooms, and boiler rooms, were provided with self-closing devices which would cause the doors to automatically close and latch into the door frames or provided with smoke resistant partitions. This deficient practice could affect as many as 10 staff in the basement. Findings include: Based on observations made with the Maintenance Director and the visiting Maintenance Director during a tour of the facility on 04/28/25 at 12:57 p.m., the Medical Records office located in the basement of the facility had over 50 accordion files of loose paper contained on shelves located throughout the office. The corridor door to this office, that measured approximately 12 feet by 10 feet in size, did not have a self-closing device attached to it. Based on an interview with the Maintenances Director on 04/28/25 at 12:59 p.m., he agreed that based on the rooms contents and size, a self-closing device was necessary and added that he would have one added to the door as soon as possible.	K 0321	1--What corrective actions will be accomplished for those residents to have been affected by the deficient practice? A self-closing device has been placed on the Medical Records office door. 2--How are other residents having the potential to be affected by the same deficient practice be identified and what corrective action (s) will be taken? A self-closing device has been placed on the Medical Records office door. 3--What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? Combustible storage rooms over 50 square feet will be audited monthly to ensure that they continue to have a self-closing device on the door.	05/19/2025

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	This item was discussed at the exit conference with the Maintenance Director, the visiting Maintenance Director and the facility Administrator held on 04/28/25. 3.1-19(b)		4--How will the corrective actions be monitored to ensure the deficient practice will not reoccur? Audit results will be reviewed and reported to the IDT in QAPI. Determination of ongoing monitoring will be completed within the QAPI process.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2, states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 states the fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 states an approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice could affect as many as 32 residents, 6 staff, and 2 visitors in the	K 0324	1--What corrective actions will be accomplished for those residents to have been affected by the deficient practice? An approved method for returning cooking appliances to where they where when the kitchen hood extinguishing equipment was designed and installed has been installed. 2--How are other residents having the potential to be affected by the same deficient practice be identified and what corrective action (s) will be taken? An approved method for returning cooking appliances to were they where when the kitchen hood extinguishing equipment was designed and installed has been installed. 3--What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? Maintenance Director/Designee will audit monthly to ensure the	05/19/2025

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	facility. Findings include: Based on observations made with the Maintenance Director and the visiting Maintenance Director during a tour of the facility on 04/28/25 at 2:10 p.m., the six (6) burner stove and the flat grill which was located on the cooking line under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and/or cleaning. Based on interview on 04/28/25 at 2:13 p.m., the Maintenance Director stated that he was not aware an approved method should be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning and that he would have something done to the kitchen stove or floor to meet code compliance as soon as possible. This item was discussed at the exit conference with the Maintenance Director, the visiting Maintenance Director and the facility Administrator held on 04/28/25. 3.1-19(b)		markings and equipment installed to ensure kitchen equipment returns to its appropriate place is completed. 4--How will the corrective actions be monitored to ensure the deficient practice will not reoccur? Audit results will be reviewed and reported to the IDT in QAPI. Determination of ongoing monitoring will be completed within the QAPI process.	
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance 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	K 0345	1--What corrective actions will be accomplished for those residents to have been affected by the deficient practice? The accurate date and time has been programmed into the fire alarm system.	05/19/2025

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	visitors. Findings include: Based on observations made with the Maintenance Director and the visiting Maintenance Director during a tour of the facility on 04/28/25 at 12:35 p.m., the time and date on the fire alarm control panel were incorrect. The display on the main fire alarm control panel indicated the date and time to be 05/10/25 at 17:45 p.m. Based on interview on 04/28/25 at 12:37 p.m., the Maintenance Director indicated he was unaware of the discrepancy and would contact his alarm company vendor to have the displayed date and time updated on the fire alarm control panel as soon as possible. This item was discussed at the exit conference with the Maintenance Director, the visiting Maintenance Director and the facility Administrator held on 04/28/25. 3.1-19(b)		2--How are other residents having the potential to be affected by the same deficient practice be identified and what corrective action (s) will be taken? The accurate date and time has been programmed into the fire alarm system. 3--What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? Maintenance Director/Designee will audit weekly to ensure the date and time on the fire alarm system. 4--How will the corrective actions be monitored to ensure the deficient practice will not reoccur? Audit results will be reviewed and reported to the IDT in QAPI. Determination of ongoing monitoring will be completed within the QAPI process.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and	K 0353	1--What corrective actions will be accomplished for those residents to have been affected by the deficient practice? Weekly dry sprinkler system gauge inspections and monthly sprinkler system control valve inspections have been documented.	05/19/2025

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	fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 04/28/25 at 9:50 a.m. with the Maintenance Director and the visiting Maintenance Director, weekly dry sprinkler system gauge inspection documentation for 52 weeks of the most recent 52-week period was not available for review. In addition, monthly inspection documentation for all sprinkler system control valves for 12 months of the most recent 12-month period was not available for review. Based on interview on 04/28/25 at 9:53 a.m. the Maintenance Director acknowledged sprinkler system gauge and control valve inspection documentation for the aforementioned weekly and monthly periods was not available for review adding that he would call Direct Supply and add it to his "Tasks to do list" as soon as possible. This item was discussed at the exit conference with the Maintenance Director, the visiting Maintenance Director and the facility Administrator held on 04/28/25. 3.1-19(b)		2--How are other residents having the potential to be affected by the same deficient practice be identified and what corrective action (s) will be taken? Weekly dry sprinkler system gauge inspections and monthly sprinkler system control valve inspections have been documented. 3--What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? Maintenance Director/Designee will audit monthly to ensure the weekly dry sprinkler system gauge inspections and the monthly sprinkler system control valve inspections have been completed. 4--How will the corrective actions be monitored to ensure the deficient practice will not reoccur? Audit results will be reviewed and reported to the IDT in QAPI. Determination of ongoing monitoring will be completed within the QAPI process.	
K 0511 SS=E	NFPA 101 Utilities - Gas and Electric			

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Bldg. 01	1) Based on observation and interview, the facility failed to ensure all electrical panels in the corridors were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. The deficient practice could affect as many as 28 residents, 6 staff, and 2 visitors in the facility. Findings include: Based on observations made with the Maintenance Director and the visiting Maintenance Director during a tour of the facility on 04/28/25 at 12:39 p.m., the electrical panel on the 200 Hall nearest to resident room #210 was unlocked when checked. Based on an interview on 04/28/25 at 12:40 p.m. , the Maintenance Director stated that he was unaware the panel was unsecured. A short time later the key to the panel was located and the Maintenance Director advised that the key had been located and that he would check all other panels throughout the facility and make sure they were secured as well. This item was discussed at the exit conference with the Maintenance Director, the visiting Maintenance Director and the facility	K 0511	1--What corrective actions will be accomplished for those residents to have been affected by the deficient practice? The electrical panel on the 200 hall nearest to resident room 210 has been locked. The exposed wires in the junction box behind the dryer has been repaired. 2--How are other residents having the potential to be affected by the same deficient practice be identified and what corrective action (s) will be taken? All electrical panels in the facility have been reviewed to ensure they have been locked. The exposed wires in the junction box behind the dryer has been repaired. 3--What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? Maintenance Director/Designee will audit weekly to ensure the electrical panels in the facility are locked. 4--How will the corrective actions be monitored to ensure the deficient practice will not reoccur? Audit results will be reviewed and reported to the IDT in QAPI. Determination of ongoing	05/19/2025

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	155215	A. BUILDING 01 B. WING	04/28/2025

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PLAINFIELD HEALTH CARE CENTER	3700 CLARKS CREEK RD PLAINFIELD, IN 46168

(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
	Administrator held on 04/28/25. 3.1-19(b) 2) Based on observation and interview, the facility failed to ensure 1 of 1 laundry room was maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, 2011 Edition, Article 314.28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect as many as 10 staff in the basement. Findings include: Based on observations made with the Maintenance Director and the visiting Maintenance Director during a tour of the facility on 04/28/25 at 1:26 p.m., there were exposed wires hanging from the junction box behind the dryers. This wire was laying on the floor and was noted to be 220 volts. Furthermore, the wires had black tape over them, but the attachment points were still somewhat exposed and definitely could cause arcing if the concrete floor got damp or wet. Based on an interview on 04/28/25 at 1:28 p.m., the Maintenance Director agreed that the exposed 220-volt wires were an issue adding that he would have something done to take care of them as soon as possible. This item was discussed at the exit conference with the Maintenance Director, the visiting Maintenance Director and the facility Administrator held on 04/28/25. 3.1-19(b)		monitoring will be completed within the QAPI process.	

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 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review, observation, and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 04/28/25 at 11:10 a.m. with the Maintenance Director and the visiting	K 0921	1--What corrective actions will be accomplished for those residents to have been affected by the deficient practice? SafeCare has been contracted to perform PCREE services on Tuesday, May 27th. 2--How are other residents having the potential to be affected by the same deficient practice be identified and what corrective action (s) will be taken? SafeCare will inspect all required PCREE in the facility to ensure functionality and compliance. 3--What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? Maintenance Director/Designee will work with SafeCare annually to ensure functionality and compliance of PCREE per CMS guidelines. 4--How will the corrective actions be monitored to ensure the deficient practice will not reoccur? Audit results will be reviewed and reported to the IDT in QAPI on a monthly basis for equipment that may not be functional. SafeCare will be alerted when audit results	06/13/2025

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	Maintenance Director, there was no documentation available for review for the testing of Patient Care Related Electrical Equipment (PCREE), such as electric beds, nebulizers, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment. Based on an interview on 04/28/25 at 11:12 a.m., the Maintenance Director said the facility has not yet tested and documented the PCREE items. Based on observations between 12:35 p.m. and 3:08 p.m. during a tour of the facility with the Maintenance Director and visiting Maintenance Director, it was revealed the facility provided PCREE such as electric beds, air pumps for air mattresses, and other electrical medical equipment was present in the facility. This item was discussed at the exit conference with the Maintenance Director, the visiting Maintenance Director and the facility Administrator held on 04/28/25. 3.1-19(b)		are presented to Administrator and/or designee.	