STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155245	A. BUILDING -- B. WING	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

(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: 09/30/24 Facility Number: 000149 Provider Number: 155245 AIM Number: 100266840 At this Emergency Preparedness survey, Castleton Health Care Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 109 certified beds. At the time of the survey, the census was 53. The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by: Quality Review completed on 10/02/24	E 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed because it is required by the provisions of federal and state law. Castleton Healthcare Center asserts that it is in substantial compliance with regulations governing the operation of long-term care facilities, and that this Plan of Correction in its entirety constitutes the providers credible allegation of compliance and respectfully is requesting paper compliance on review.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.1 Develop EP Plan, Review and Update Annually Based on record review and interview, the facility failed to maintain 1 of 1 emergency preparedness plans that were reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness	E 0004	**E004** **General Requirements –** The emergency preparedness plan has been reviewed and updated as necessary by the facility IDT team. An AD-HOC QAPI was held on 10.7.2024 for annual review and will be held annually thereafter at the start of each calendar year.	10/14/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
William McCallum	Regional Director of Ops	10/14/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	Book" documentation dated 05/24/22 with the Maintenance Director during record review from 9:30 a.m. to 12:10 p.m. on 09/30/24, emergency preparedness program documentation which was reviewed within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated the 05/24/22 documentation was the nurse's station version of emergency preparedness documentation, the Administrator's copy was not available for review at the time of the survey and agreed emergency preparedness program documentation was not documented as being reviewed within the most recent twelve month period. These findings were not reviewed with the Maintenance Director during the exit conference.		Facility has completed onsite inspection by the requirement, with Compliance date of 10.14.2024 **Method to Assess:** The facility administrator and director of plant operations have reviewed all facility copies to ensure accuracy and review of EP plan has been completed. **Systematic Process:** Quality Assurance Executive Director/Designee will present results of any visual inspection to the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418 Plan Based on All Hazards Risk Assessment Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach which was reviewed within the most recent twelve month period and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants. Findings include:	E 0006	**E006** **General Requirements** – The facility IDT completed an annual facility/community-based hazard vulnerability assessment for the calendar year of 2024. The IDT will continue to monitor this assessment for any necessary changes related to the facility and/or community. Facility has completed onsite inspection by the requirement, with Compliance date of 10.14.2024	10/14/2024

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	Based on review of "Emergency Preparedness Book" documentation dated 05/24/22 with the Maintenance Director during record review from 9:30 a.m. to 12:10 p.m. on 09/30/24, a documented facility-based and community-based risk assessment reviewed by the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated the 05/24/22 documentation was the nurse's station version of emergency preparedness documentation, the Administrator's copy was not available for review at the time of the survey and agreed a documented facility-based and community-based risk assessment reviewed by the facility within the most recent twelve month period was not available for review. These findings were not reviewed with the Maintenance Director during the exit conference.		**Method to Assess:** The facility administrator and Director of plant operations have reviewed all facility copies to ensure accuracy of facility and hazards vulnerability plan. **Systematic Process**: Quality Assurance Executive Director/Designee will present results of any visual inspection to the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.1 Development of EP Policies and Procedures Based on record review and interview, the facility failed to review and update its emergency preparedness policies annually. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness Book" documentation dated 05/24/22 with the Maintenance Director during record review from 9:30 a.m. to 12:10 p.m. on 09/30/24, emergency preparedness policies and procedures reviewed within the most recent twelve month period was	E 0013	**E013** **General Requirements –** The emergency preparedness plan has been reviewed and updated as necessary by the facility IDT team. An AD-HOC QAPI was held on 10.7.2024 for annual review and will be held annually thereafter at the start of each calendar year. Facility has completed onsite inspection by the requirement, with Compliance date of 10.14.2024 **Method to Assess:** The facility	10/14/2024

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	not available for review. Based on interview at the time of record review, the Maintenance Director stated the 05/24/22 documentation was the nurse's station version of emergency preparedness documentation, the Administrator's copy was not available for review at the time of the survey and agreed emergency preparedness policies and procedures reviewed within the most recent twelve month period was not available for review. These findings were not reviewed with the Maintenance Director during the exit conference.		administrator and Director of plant operations have reviewed all facility copies to ensure accuracy of facility and hazards vulnerability plan. **Systematic Process**: Quality Assurance Executive Director/Designee will present results of any visual inspection to the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.1 Development of Communication Plan Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws which was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness Book" documentation dated 05/24/22 with the Maintenance Director during record review from 9:30 a.m. to 12:10 p.m. on 09/30/24, documentation for a complete emergency preparedness communication plan reviewed by the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director	E 0029	**E029** **General Requirements –** The emergency preparedness "communication" plan has been reviewed and updated as necessary by the facility IDT team. An AD-HOC QAPI was held on 10.7.2024 for annual review and will be held annually thereafter at the start of each calendar year. Facility has completed onsite inspection by the requirement, with Compliance date of 10.14.2024 **Method to Assess:** The facility administrator and Director of plant operations have reviewed all facility copies to ensure accuracy	10/14/2024

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	stated the 05/24/22 documentation was the nurse's station version of emergency preparedness documentation, the Administrator's copy was not available for review at the time of the survey and agreed documentation for a complete emergency preparedness communication plan reviewed by the facility within the most recent twelve month period was not available for review. These findings were not reviewed with the Maintenance Director during the exit conference.		of facility and hazards vulnerability plan. **Systematic Process**: Quality Assurance Executive Director/Designee will present results of any visual inspection to the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.1 EP Training and Testing Based on record review and interview, the facility failed to develop and maintain emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness Book" documentation dated 05/24/22 with the Maintenance Director during record review from 9:30 a.m. to 12:10 p.m. on 09/30/24, the facility's emergency preparedness training and testing program documentation was not reviewed within the most recent twelve month period. Based on interview at the time of record review, the Maintenance Director stated the 05/24/22 documentation was the nurse's station version of emergency preparedness documentation, the Administrator's copy was not available for review at the time of the survey and agreed the facility's	E 0036	**E036** **General Requirements –** The emergency preparedness "Testing" plan has been reviewed and updated as necessary by the facility IDT team. An AD-HOC QAPI was held for annual review and will be held annually thereafter at the start of each calendar year. Facility has completed onsite inspection by the requirement, with Compliance date of 10.14.2024 **Method to Assess:** The facility administrator and Director of plant operations have reviewed all facility copies to ensure accuracy of facility training and testing plan as well as education for existing employee and new hire education within orientation. All employees	10/14/2024

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	emergency preparedness training and testing program documentation was not reviewed within the most recent twelve month period. These findings were not reviewed with the Maintenance Director during the exit conference.		are assigned virtual education annually that will aid and assist in the development of training plan. **Systematic Process**: Quality Assurance Executive Director/Designee will present results of any visual inspection to the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(EP Training Program Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d)(1). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness Book" documentation dated 05/24/22 with the Maintenance Director during record review from	E 0037	**E037** **General Requirements –** The emergency preparedness "training and testing" plan has been reviewed and updated as necessary by the facility IDT team. An AD-HOC QAPI was held on 10.7.2024 for annual review and will be held annually thereafter at the start of each calendar year. Facility has completed onsite inspection by the requirement, with Compliance date of 10.14.2024 The facility has implemented the following: IDT completed a table-top exercise on 10.7.2024 (active Shooter)	10/14/2024

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	9:30 a.m. to 12:10 p.m. on 09/30/24, documentation for staff training on emergency preparedness within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated the 05/24/22 documentation was the nurse's station version of emergency preparedness documentation, the Administrator's copy was not available for review at the time of the survey and agreed annual staff training documentation on the emergency preparedness program conducted within the most recent twelve month period was not available for review. These findings were not reviewed with the Maintenance Director during the exit conference.		Implemented EP training and review on orientation Assigned routine training for all existing employees via electronic education platform. **Method to Assess:** The Facility Administrator and Director of Plant operations have reviewed all facility copies to ensure accuracy of facility and hazards vulnerability plan. **Systematic Process**: Quality Assurance Executive Director/Designee will present results of any visual inspection to the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
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: 09/30/24 Facility Number: 000149 Provider Number: 155245 AIM Number: 100266840	K 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed because it is required by the provisions of federal and state law. Castleton Healthcare Center	

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	At this Life Safety Code survey, Castleton Health 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 one story facility was determined to be of Type V (111) construction and 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 109 and had a census of 53 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 10/02/24		asserts that it is in substantial compliance with regulations governing the operation of long-term care facilities, and that this Plan of Correction in its entirety constitutes the providers credible allegation of compliance and respectfully is requesting paper compliance on review.	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Based on observation and interview, the facility failed to ensure 1 of 8 exit discharges was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 10 residents, staff and visitors if needing to exit the facility from the dining room near the center lobby. Findings include: Based on observations with the Maintenance	K 0271	**K271** **General Requirements –** The identified bicycle lock was removed from the fenced area, with the area being free from obstruction or impediments to full instant use. Facility has completed onsite inspection per requirement, with Compliance date of 10.14.2024 **Method to Assess**: The director	10/14/2024

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	Director during a tour of the facility from 12:25 p.m. to 2:00 p.m. on 09/30/24, the exit door which lead to the outside of the facility for the dining room was marked as a facility exit with an exit sign. The door was magnetically locked and could be opened by entering a code into a keypad at the exit door. The correct code to release the exit door to open was posted at the exit door. The exit discharge for the dining room exit was in a fenced in area and had one gate in the fence which led to the public way. The gate was locked with bicycle lock wrapped through the chain link fence and gate. The bicycle lock was a combination lock with the combination not posted on or near the lock. Based on interview at the time of the observations, the Maintenance Director stated only staff knew the combination to release the bicycle lock and agreed the aforementioned exit discharge was not free of obstruction or impediments to full instant use. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		of plant operations visually inspected all areas of exit, including courtyards and fenced areas to ensure no other obstructions/impediments were identified or out of compliance related to inspection. **Systematic Process**: Quality Assurance Executive Director/Designee will present results of any visual inspection to the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Based on record review, observation and interview; the facility failed to document monthly testing for all battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2).	K 0291	**K291** **General Requirements –** Functional testing was completed for all battery powered backup lights. Facility has completed onsite inspection per requirement, with Compliance date of 10.14.2024. All testing will be on-going every 30 days thereafter. **Method to Assess**: The director	10/14/2024

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	(2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (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, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook "Emergency Lighting: Conduct a 30 second functional test" documentation for the most recent twelve month period with the Maintenance Director during record review from 9:30 a.m. to 12:10 p.m. on 09/30/24, monthly battery operated light testing documentation for March 2024 through August 2024 was not available for review. Based on interview at the time of record review, the Maintenance Director stated the monthly task of functional testing is automatically assigned by TELS and he completed battery light testing for the six month period of March 2024 through August 2024 but he cannot generate a completed report in TELS because TELS has the report listed as "retired". The Maintenance Director stated he cannot change or update the ability to generate a report in TELS for battery light testing and agreed monthly battery operated light testing documentation for March 2024 through August 2024 was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:00		of plant operations visually inspected all battery powered backup lights to ensure requirement is maintained. **Systematic Process**: Quality Assurance Executive Director/Designee will present results of any visual inspection to the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	

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	p.m. on 09/30/24, two separate battery operated light locations in the facility were noted. One is located inside the main mechanical room at the automatic transfer switch for the facility's emergency generator and the second location is outside the facility at the emergency generator. Each battery operated light illuminated when its respective test button was pushed. These findings were reviewed with the Maintenance Director during the exit conference. 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 1 of over 9 hazardous areas such as trash collection rooms (exceeding 64 gallons) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors in the main dining room. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:00 p.m. on 09/30/24, over two 32 gallon capacity portable trash containers were stored in the kitchen. The entry door to the kitchen from the main dining room was equipped with a self closing device and latching hardware but the door failed to fully self close and latch into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned	K 0321	**K321** **General Requirements –** The identified Kitchen door was inspected, repaired and audited for appropriate latching/closing mechanisms, the door functions as properly. The identified portable trash containers were removed from the Dietary area of the building immediately. The facility has completed onsite inspection by the requirement, with Compliance date of 10.14.2024 Method to Assess: The director of plant operations visually inspected all self-closing doors within the facility to ensure that all latching mechanisms functioned properly.	10/14/2024

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	hazardous area was not separated from other spaces by smoke resistant partitions and doors due to the kitchen door not self closing and latching into the door frame. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		**Systematic Process**: Quality Assurance Executive Director/Designee will present results of any visual inspection to the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
K 0341 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Installation Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 10.5.5.1 states connections to the light and power service shall be on a dedicated branch circuit(s). Circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT. The location of the circuit disconnecting means shall be permanently identified at the fire alarm control unit. Section 10.5.5.4 states an overcurrent protective device of suitable current carrying capacity and capable of interrupting the maximum short circuit current to which it may be subject shall be provided in each ungrounded conductor. The dedicated branch circuit(s) and connections shall be protected against physical damage. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance	K 0341	**K341** **General Requirements –** The identified electrical room door was immediately locked and inspected. The identified electrical panel housing the fire alarm breaker was locked and inspected. The Director of Plant operations and dietary director were educated on authorized personnel access only per requirement. The facility has completed onsite inspection by the requirement, with Compliance date of 10.14.2024 **Method to Assess**: The director of plant operations visually inspected all breaker boxes within the facility to ensure that all latching and lock mechanisms functioned properly. **Systematic Process**: Quality Assurance Executive	10/14/2024

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	155245	A. BUILDING 01 B. WING	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

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	Director during a tour of the facility from 12:25 p.m. to 2:00 p.m. on 09/30/24, access to the fire alarm system breaker located in the electrical panel in the electrical room in the kitchen was not restricted to authorized personnel. The entrance door to the room was equipped with a lock on the door handle but the door was not locked. Neither the electrical panel housing the fire alarm breaker nor the fire alarm breaker was locked. Based on interview at the time of the observations, the Maintenance Director agreed access to the fire alarm system breaker was not restricted to authorized personnel. 3.1-19(b)		Director/Designee will present results of any visual inspection to the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
K 0345 SS=F Bldg. 01	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, National Fire Alarm Code as required by LSC 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 residents, staff and visitors.	K 0345	**K345** **General Requirements –** The identified fire alarm system inspection has been provided for supporting documentation and scheduled as semi-annual. All documentation will be kept for record keeping per requirement. The Director of Plant operations was educated on system inspection and record keeping. The facility has completed onsite inspection by the requirement, with Compliance date of 10.14.2024 **Method to Assess**: The director of plant operations visually inspected all fire alarm systems for function within the facility to ensure function per requirement.	10/14/2024

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	Findings include: Based on review of the fire alarm system inspection contractor's "Fire Alarm System Inspection" documentation dated 09/11/23 and "Fire Alarm System Inspection" documentation dated 09/06/24 with the Maintenance Director during record review from 9:30 a.m. to 12:10 p.m. on 09/30/24, visual semi-annual fire alarm system inspection documentation six months after 09/11/23 was not available for review. Based on interview at the time of record review, the Maintenance Director agreed visual semi-annual inspection documentation for the facility's fire alarm system six months after 09/11/23 was not available for review. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		**Systematic Process**: Quality Assurance Executive Director/Designee will present results of any visual inspection to the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
K 0353 SS=F Bldg. 01	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 1 of 4 quarters. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition. NFPA 25, Section 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, Section 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. NFPA 25, Section 4.3.1 requires records	K 0353	**K353** **General Requirements –** The identified sprinkler system inspection has been renewed and scheduled quarterly per requirement. The Director of Plant operations was educated on system inspection and record keeping. The facility has completed onsite inspection by the requirement, with Compliance date of 10.14.2024. The identified data cables were raised off and secured above the sprinkler piping, correcting the identified	10/14/2024

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	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. NFPA, 25 Section 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. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of the sprinkler system inspection contractor's "Sprinkler: Report of Inspection" documentation dated 12/06/23, 03/11/24 and 09/06/24 with the Maintenance Director during record review from 9:30 a.m. to 12:10 p.m. on 09/30/24, no second quarter (April, May, June) 2024 sprinkler system inspection documentation was available for review. Based on interview at the time of record review, the Maintenance Director stated the sprinkler system inspection contractor was revising their inspection and testing contract with the facility during the second quarter 2024 and agreed it had been more than 90 days in between quarterly sprinkler system inspection and testing on 03/11/24 and 09/06/24. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain 1 of 1 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		observation. **Method to Assess**: The director of plant operations visually inspected all fire alarm systems for function within the facility to ensure function per requirement. The director of plant operations assessed the attic space and corrected any identified concern related to **Systematic Process**: Quality Assurance Executive Director/Designee will present results of any visual inspection to the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	

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	Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Section 5.2.2.2 requires sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of resident sleeping Room 121. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:00 p.m. on 09/30/24, data cables were resting on two separate sections of horizontal sprinkler piping in the attic above the corridor outside resident sleeping Room 121 as observed from the attic access door near the exit door to the outside of the facility. Based on interview at the time of the observations, the Maintenance Director agreed sprinkler piping in the attic was subjected to external loads by materials resting on the pipe. These findings were reviewed with the Maintenance Director during the exit conference 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of over 60 corridor doors would resist the passage of smoke. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Community Room by resident sleeping Room 220. Findings include:	K 0363	**K363** **General Requirements –** The identified “half inch hole” has been repaired above the door handle of the community room per requirement. The Director of Plant operations was educated on corridor doors, smoke passage, and fire protection. The facility has	10/14/2024

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	Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:00 p.m. on 09/30/24, the corridor door to the Community Room by resident sleeping Room 220 had a one half inch diameter hole in the door above and below the door handle which would not resist the passage of smoke. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned corridor door would not resist the passage of smoke. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		completed onsite inspection by the requirement, with Compliance date of 10.14.2024 **Method to Assess**: The director of plant operations visually inspected smoke passage doors for function/repair within the facility to ensure appropriate function per requirement. **Systematic Process**: Quality Assurance Executive Director/Designee will present results of any visual inspection to the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
K 0761 SS=F Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in	K 0761	**K761** **General Requirements –** An annual inspection was completed on 10.11.2024 and identified all annual fire inspection doors from the annual 2023 report. The Director of Plant operations was educated on annual inspections and record keeping. The facility has completed onsite inspection by the requirement, with Compliance date of 10.14.2024 **Method to Assess**: The director	10/14/2024

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	accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents,		of plant operations visually inspected smoke passage doors for function/repair within the facility to ensure appropriate function per requirement. **Systematic Process**: Quality Assurance Executive Director/Designee will present results of any visual inspection to the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	

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	staff and visitors. Findings include: Based on review of the fire door inspection contractor's "Swing Door Inspection" documentation dated 09/26/24 with the Maintenance Director during record review from 9:30 a.m. to 12:10 p.m. on 09/30/24, annual fire door inspection documentation for the most recent twelve month period did not include all fire doors in the facility. The 09/26/24 fire door inspection documentation only included fire door locations in the two corridor door sets near the center lobby identified as "(3A) and (3B) and (4A) and (4B). Review of the fire door inspection contractor's fire door inspection documentation dated 06/14/23, which was more than twelve months old, indicated the facility has additional fire door locations at the central supply room, the oxygen storage room and at the fire rated attic access doors at the end of each resident sleeping room wing. Based on interview at the time of record review, the Maintenance Director stated additional fire door inspection documentation for the most recent twelve month period was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:00 p.m. on 09/30/24, the corridor door to the central supply room had a fire resistance rating label affixed to the hinge side of the door indicating it was rated at 90-minutes. The oxygen storage room inside the central supply room had a fire resistance rating label affixed to the hinge side of the door indicating it was rated at 1-hour fire resistance rating. Five liquid oxygen containers and eight 'E' type oxygen cylinders were stored in the room. Attic access doors in the ceiling in each wing were equipped with a 90-minute fire resistance rating label.			

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	These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)			