STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155086	A. BUILDING -- B. WING	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLAND MANOR	343 S NAPPANEE ST ELKHART, IN 46514

(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: 05/29/25 Facility Number: 000034 Provider Number: 155086 AIM Number: 100274880 At this Emergency Preparedness survey, Woodland Manor was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 80 certified beds. At the time of the survey, the census was 70. Quality Review completed on 06/02/25	E 0000		
K 0000 Bldg. 01	A Life Safety Code (LSC) Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/29/25 Facility Number: 000034 Provider Number: 155086 AIM Number: 100274880 At this LSC survey, Woodland Manor was found not in compliance with Requirements for	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacy Cromer	QAA	06/10/2025

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.

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	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 II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and areas open to the corridor and battery-operated smoke detectors in the resident rooms. The building is partially protected by a Type II EES 33 kW diesel-powered emergency generator. The facility has a capacity of 80 and had a census of 70 at the time of this survey. Quality Review completed on 06/02/25			
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Based on observation record review and interview; the facility failed to ensure battery-operated smoke alarms were maintained. 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, National Fire Alarm and Signaling Code, 2010 Edition, Section 29.10 states fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. Section 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. Section 14.4.8.1 states unless otherwise recommended by the	K 0300	**Requesting a Desk Review for all citations** **K300** **What corrective actions will be accomplished for those residents found to have been affected?** No resident identified as being affected in this statement of deficiency Weekly testing of the battery-operated smoke alarms was completed during the survey process and will be completed weekly and documented by the Maintenance Director/designee.	06/20/2025

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	manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Administrator, Senior Maintenance Director, Maintenance Director and Quality Assurance Administrator at 10:28 a.m. on 05/29/2025, the facility provided documentation of monthly battery-operated smoke detectors and annual battery replacement but failed to show cleaning or weekly testing per manufacturer's instructions. Based on observation with the Administrator, Senior Maintenance Director, Maintenance Director and Quality Assurance Administrator at 11:07 a.m. on 05/29/2025, the facility had battery operated smoke detectors in resident rooms. The manufacturer's label affixed to the smoke detector stated they were to be tested weekly and cleaned annually. The Maintenance Director stated that the "TELS" maintenance program only included monthly battery-operated smoke detector testing. After discussion with the Administrator and Senior Maintenance Director the Maintenance Director acknowledged that weekly testing was not completed. This finding was reviewed with the Administrator, Senior Maintenance Director, Maintenance Director and Quality Assurance Administrator at exit conference. 3.1-19(b)		**How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected Weekly testing of the battery-operated smoke alarms was completed during the survey process and will be completed weekly and documented by the Maintenance Director/designee. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Administrator/designee will provide education to the Maintenance Director/designee on the requirement to complete weekly testing and documentation of battery operated smoke alarms. Weekly testing of battery operated smoke alarms were uploaded in TELS so documentation can be completed after testing each week. Routine auditing of the weekly fire alarm testing documentation to be completed by the Administrator as noted below. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put**	

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			into place? Admin/Designee will audit weekly documentation showing smoke alarm testing completed weekly for 2 then monthly for 4 months to ensure testing and documentation completed. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the auditing 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* 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.	K 0324	**K324** **What corrective actions will be accomplished to address the deficient practice?** No resident was identified as being affected in this statement of deficiencies. Designated area was outlined on 6/10/2025 where the fryer is located under fire suppression hood was outlined and dietary staff educated regarding where it must	06/20/2025

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	Section 12.1.2.3 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 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. This deficient practice could affect kitchen staff only. Findings include: Based on observation with the Maintenance Director at 12:27 p.m. on 05/29/2025, a deep fat fryer located under the exhaust 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 cleaning. Based on interview with the Maintenance Director, he was not aware that an approved method should be provided to ensure that the appliance were returned to an approved design location after maintenance or cleaning. This finding was reviewed with the Administrator, Senior Maintenance Director, Maintenance Director and Quality Assurance Administrator at exit conference. 3.1-19(b)		stay by the Administrator. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All res have the potential to be affected Designated area was outlined where the fryer is located under fire suppression hood was outlined and dietary staff educated regarding where it must stay. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Administrator/designee will provide education to the dietary associates on the requirement that the fryer remain under the fire suppression hood. Yellow tape has been placed on floor in area where the fryer sits under fire suppression hood. Staff educated on this practice and that fryer should remain in this area. Routine auditing to be completed as noted below.	

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			How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? Administrator/Designee will randomly audit the kitchen 3x weekly on all shifts for 30 days then 1x weekly for 30 days then monthly for 4 months to ensure proper placement of fryer at all times. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the auditing process.	
K 0345 SS=C	NFPA 101 Fire Alarm System - Testing and			

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Bldg. 01	Maintenance Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation with the Maintenance Director at 12:38 p.m. on 05/29/2025, the fire control panel time indicated 1:18 p.m. on 05/29/2025. Based on interview at time of observation the Maintenance Director acknowledged the time on the fire control panel was incorrect. This finding was reviewed with the Administrator, Senior Maintenance Director, Maintenance Director and Quality Assurance Administrator at exit conference. 3.1-19(b)	K 0345	**K345** **What corrective actions will be accomplished for those residents found to have been affected?** No resident identified as being affected in this statement of deficiency Fire Alarm corrected on 6/5/2025 set correct time and ensured fire alarm was in complete working order and is functioning properly. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected Fire Alarm was corrected on 6/5/2025 to set correct time and ensured fire alarm was in complete working order and is functioning properly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director will be trained by the Administrator/designee on validating fire alarm time is correct to ensure full working order of fire alarm panel. The Administrator/designee will complete routine auditing as noted	06/20/2025

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			below. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Administrator/Designee to audit fire alarm panel 3x weekly for 30 days then weekly for 30 days then monthly for four months. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the auditing process.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 2 of 2 electrical receptacles were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code.	K 0511	**K511** **What corrective actions will be accomplished for those residents found to have been affected?** No resident was identified as being affected in this statement of	06/20/2025

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	NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in		deficiencies 2 electrical receptacles were replaced with GFCI on 6.4.2025. All other receptacles were audited to ensure correct and working order. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents could be affected 2 electrical receptacles were replaced with GFCI on 6.4.2025. All other receptacles were audited to ensure correct and working order. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director will be inserviced by the Administrator/designee on the requirement that GFCI receptacles are in all areas needed and in working order. Routine auditing to be completed as noted below. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Administrator/Designee to audit 3 random GFCI receptacles weekly for 30 days then then 1 weekly for	

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	patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used. This deficient practice could affect residents, staff and visitors in the Therapy room. Findings include: Based on observation with the Maintenance Director at 1:20 p.m. on 05/29/2025, a GFCI type electrical receptacle was located 9 ½ inches to the right of a hand washing sink in the Therapy room. When the GFCI electrical receptacle was tested with a GFCI tester, it failed to trip and did not break the electrical circuit. A second receptacle of a standard type was located 24 inches from a second handwashing sink in the Therapy room. When the second electrical receptacle was tested with a GFCI tester, it failed to trip and did not break the electrical circuit. Based on interview with the Maintenance Director at 1:20 p.m. on 05/29/2025, he agreed both electric receptacles did not properly work when tested and the electrical receptacles were both within 6 feet of a sink. This finding was reviewed with the Administrator, Senior Maintenance Director, Maintenance Director and Quality Assurance Administrator at exit conference. 3.1-19(b)		30 days then monthly for 4 months. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the auditing process.	

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K 0761 SS=F Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on record review and interview, the facility failed to ensure annual inspection and testing of 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 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.	K 0761	**K761** **What corrective actions will be accomplished for those residents found to have been affected?** No resident was identified as being affected in this statement of deficiencies. All annual fire doors were tested on 6/10/2025 and are functioning properly. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents could be affected All annual fire doors were tested on 6/10/2025 and are functioning properly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Annual Fire door testing uploaded in TELS to ensure all fire doors are tested annually. Maintenance Director will be trained on this requirement by the Administrator/designee. Routine auditing will be completed by the Administrator/designee as noted below.	06/20/2025

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	(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, staff and visitors. Findings include: Based on record review with the Administrator, Senior Maintenance Director, Maintenance Director and Quality Assurance Administrator at 10:37 a.m. on 05/29/2025, the facility failed to provide documentation of annual fire door inspections in the last 12 month period. The facility provided documentation of fire and smoke door assembly inspections conducted on 03/18/2024. Based on interview with the Maintenance Director at 10:37 a.m. on 05/29/2025, he stated he did not conduct fire and smoke door assembly inspections since he was hired in February of 2025. This finding was reviewed with the Administrator, Senior Maintenance Director, Maintenance Director and Quality Assurance Administrator at exit conference. 3.1-19(b)		**How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Administrator/Designee will audit to ensure all fire doors are tested and documented in June every year. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the auditing process.	

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K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Based on observation, record review and interview, the facility failed to ensure all non-hospital-grade electrical receptacles at resident room locations were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Administrator, Senior Maintenance Director, Maintenance Director and Quality Assurance Administrator at 10:56 a.m. on 05/29/2025, the facility was not able to provide documentation of annual testing of electrical receptacles. Based on observation with the Maintenance Director during tour of the facility from 11:50 a.m. to 2:00 p.m. on 05/29/2025, non-hospital-grade electrical receptacles were in use in all resident rooms throughout the facility. Based on interview, the Maintenance Director stated he did not test the electrical receptacles;	K 0914	**K914** **What corrective actions will be accomplished for those residents found to have been affected?** No resident was identified as being affected in this statement of deficiency. Non hospital grade electrical receptacles were tested by 6/13/2025. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected. All non hospital grade electrical receptacles will be tested annually. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Regional Maintenance Director/Designee will do education with Maintenance on the requirement to complete annual no hospital grade electrical receptacles annually. **How will the corrective actions be monitored to ensure the**	06/20/2025

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	155086	A. BUILDING 01 B. WING	05/29/2025

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	however, they planned to do the testing when they do the PCREE testing. These findings were reviewed with the Administrator, Senior Maintenance Director, Maintenance Director and Quality Assurance Administrator at exit conference. 3.1-19(b)		**deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Administrator/designee will audit annually to ensure all non hospital grade electrical receptacles testing is completed. This testing will be completed every June going forward. The results of these revies will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months then quarterly thereafter once full compliance has been achieved for the total of 6 months monitoring. Re-education, frequency and or duration of reviews will be increased as needed, if areas of noncompliance are identified through the auditing process.	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review 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	K 0921	**K 921 Electrical Equipment - Testing and Maintenance** **What corrective actions will be accomplished for those residents found to have been affected?** No resident was identified as being affected in this statement of deficiencies. The Maintenance Director/designee will complete	06/20/2025

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	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 with the Administrator, Senior Maintenance Director, Maintenance Director and Quality Assurance Administrator on 05/29/2025 at 10:43 a.m., the facility failed to provide documentation of testing of Patient Care Related Electrical Equipment (PCREE) in use in the facility as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Based on interview with the Maintenance Director on 05/19/2025 at 10:43 a.m., he stated the company had recently purchased appropriate testing equipment for the facility to conduct the testing but they have not received the equipment or training. 3.1-19(b)		and document Patient Care Related Electrical Equipment (PCREE) testing by June 20th, 2025) as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected The Maintenance Director/designee will complete and document Patient Care Related Electrical Equipment (PCREE) testing by June 20th, 2025) as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Administrator/designee will provide education to the Maintenance Director/designee on the requirement to ensure PCREE testing is completed and documented annually and before new equipment is used by a resident. The Maintenance Director/designee will complete routine auditing to ensure that PCREE testing is being	

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			completed annually and before new equipment is used by residents. Auditing as noted below. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** The Maintenance Director/designee will complete routine auditing to ensure that PCREE testing is being completed annually and before resident use of new equipment. Auditing to be completed annually in June along with all new admissions to be completed upon admission. 3 new admissions if applicable will be audited weekly x 30 days then 3 new admissions audited monthly xs 1 month then 3 new admissions audited monthly for 4 months The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the auditing process.	

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