STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155649	A. BUILDING -- B. WING	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION AND HEALTHCARE	210 STATE HWY 43 SPENCER, IN 47460

(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: 02/19/25 Facility Number: 010478 Provider Number: 155649 AIM Number: 200197620 At this Emergency Preparedness survey, McCormick's Creek Rehabilitation and Healthcare was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 87 certified beds. At the time of the survey, the census was 80. Quality Review completed on 02/24/25	E 0000	This plan of correction is submitted as required under Federal and State Regulation and statues applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied. The facility respectfully requests a desk review and consideration of paper compliance 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: 02/19/25 Facility Number: 010478 Provider Number: 155649 AIM Number: 200197620	K 0000	This plan of correction is submitted as required under Federal and State Regulation and statues applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
sara hatfield	Executive Director	03/07/2025

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	At this Life Safety Code survey, McCormick's Creek Rehabilitation and Healthcare 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 was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, all areas open to the corridor and has smoke detectors hardwired to fire alarm system in all resident sleeping rooms. The facility has a capacity of 87 and had a census of 80 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 02/24/25		constitute an agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied. The facility respectfully requests a desk review and consideration of paper compliance for this plan of correction .	
K 0324 SS=F Bldg. 01	NFPA 101 Cooking Facilities 1. Based on observation and interview, the facility failed to ensure staff were instructed in the proper use of the UL 300 hood fire suppression system in 1 of 1 kitchen. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 10.5.7 states instruction shall be provided to employees regarding the proper use of portable fire extinguishers and the manual activation of fire-extinguishing equipment. Section 11.1.4 states instructions for manually operating the fire	K 0324	**K324: Cooking Facilities** **The facility requests paper compliance for this citation.*This Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts**	03/18/2025

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	extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect kitchen staff plus all residents while in the adjoining main dining room. Findings include: Based on observations on 02/19/25 between 1:45 p.m. and 4:00 p.m. during a tour of the facility with the Executive Director from a sister facility, Senior Maintenance Director, and Director of Plant Operations from a sister facility, the main kitchen was provided with a UL 300 hood system. Based on interview with the Kitchen Manager, when asked what they would do first if there was a fire underneath the range hood and the range hood suppression system had not automatically activated, she said she would pull the fire alarm system and then grab the silver fire extinguisher. When asked where she would pull it, she said right outside the kitchen door. She did not mention activating the pull station for the range hood suppression system. This was acknowledged by the Senior Maintenance Director and Director of Plant Operations at the time of observation and interview with the Kitchen Manager. This finding was reviewed with the Executive Director from a sister facility, Senior Maintenance Director, and Director of Plant Operations from a sister facility during the exit conference. 3.1-19(b) 2. 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		***alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*****1)Immediate actions taken for those residents identifiedNo resident was found to be affected by the finding.2)How the facility identified other residents:Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice3) Measures put into place/ System changes:1. Facility has ensured the staff in the kitchen have been reeducated on the use of portable fire extinguishing equipment in the kitchen. 2. Kitchen Staff was re-educated on the proper use of the UL300 hood fire suppression system in 1 of 1 kitchen. 3. The kitchen stove nozzles were realigned immediately and an area was marked on the floor for the stove to be in at all times. Random audits will be done 3 x weekly to ensure that this practice is efficient. 4)How the corrective actions will be monitored:The Maintenance Director/designee has re-educated kitchen staff members on proper use of the	

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	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 mostly kitchen staff. Findings include: Based on observations on 02/19/25 between 1:45 p.m. and 4:00 p.m. during a tour of the facility with the Executive Director from a sister facility, Senior Maintenance Director, and Director of Plant Operations from a sister facility, the gas stove located under the range hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved designed location after it had been moved for maintenance and/or cleaning. Furthermore, one of two suppression nozzles for the gas stove cooking surface was not aligned over the cooking surface, it was pointing directly		**UL300 hood fire suppression system. Maintenance Director/designee will audit 5 kitchen staff members weekly to ensure proper understanding on usage for 6 months. The nozzles and placement of the stove will be audited 3 x weekly to ensure placement is correct. The audit will be reviewed in Quality Assurance Meeting monthly to ensure no changes or until 100% of education has been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 03/18/2025**	

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	over the solid metal shelf above the cooking surface of the stove. Based on interview at the time of observations, the Senior Maintenance Director and Director of Plant Operations were not aware that an approved method had to be provided to ensure the appliances were returned to an approved designed location after maintenance or cleaning, and were not aware that one of two suppression nozzles was not aligned over the stove cooking surface. This finding was reviewed with the Executive Director from a sister facility, Senior Maintenance Director, and Director of Plant Operations from a sister facility during the exit conference. 3.1-19(b)			
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to ensure documentation was available to show 33 of 92 smoke detectors were sensitivity tested within the past 24 months. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its	K 0345	What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified as being affected by the alleged deficient practice. No other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Certa Site coming on 3/18/25 to do the sensitivity test on all smoke detectors in the buildings	03/18/2025

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	listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 02/19/25 between 10:15 a.m. and 1:45 p.m. with the Executive Director from a sister facility, Senior Maintenance Director, and Director of Plant Operations from a sister facility present, the facility was able to produce a smoke detector sensitivity report dated 03/03/24, however, only 59 of the 92 smoke detectors were tested for sensitivity. Based on interview at the time of record review, the Senior Maintenance Director confirmed there was no smoke detector sensitivity testing documentation available for the remaining 33 smoke detectors during the past 24 months. He further said he was not sure why the remaining smoke detectors had not been tested for sensitivity.		What measures will be put in place to and what systemic changes will be made to ensure that the deficient practice does not recur: This item will be placed in our TELS protocol and will be brought to QA bi-annually to ensure that it is completed. Staff were educated and in serviced on this deficiency. How the Executive Director or designee will ensure that certa-site is on a two year schedule to complete sensitivity testing. Results will be reviewed monthly in the QAPI meeting.	

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	This finding was reviewed with the Executive Director from a sister facility, Senior Maintenance Director, and Director of Plant Operations from a sister facility during the exit conference. 3.1-19(b)			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure sprinkler heads in 2 of 3 porch overhangs covered with corrosion were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect at least 10 resident, as well as staff and visitors. Findings include: Based on observations on 02/19/25 between 1:45 p.m. and 4:00 p.m. during a tour of the facility with the Executive Director from a sister facility, Senior Maintenance Director, and Director of Plant Operations from a sister facility, the following was noted: a. There were three sprinkler heads under the south entrance/exit porch and carport overhang covered with corrosion. b. There were three sprinkler heads under the screened-in porch overhang leading to the	K 0353	**K353** **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:** **No residents were identified as being affected by the alleged deficient practice.** The Maintenance Director or designee will inspect the dry sprinkler system heads weekly. All deficient sprinkler heads that were identified during the inspection will be replaced by a qualified contractor. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The Maintenance Director or designee will complete and record the results of the dry sprinkler system heads inspection. Sprinkler heads will be inspected routinely by the maintenance director or designee to ensure they are free from corrosion. How the corrective actions will be monitored to ensure the deficient	03/18/2025

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	courtyard covered with corrosion. Based on interview at the time of each observation, the Senior Maintenance Director and Director of Plant Operations acknowledged the previously mentioned sprinkler heads were covered with corrosion. This finding was reviewed with the Executive Director from a sister facility, Senior Maintenance Director, and Director of Plant Operations from a sister facility during the exit conference. 3.1-19(b)		practice does not recur. The Executive Director will audit monthly for to ensure there is no corrosion on sprinkler heads for 6 months. The Maintenance Director or designee is to complete audit of affected sprinkler heads weekly x 4 weeks and then monthly x 5 months. These results will be reviewed and discuss at the monthly QAPI meeting.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 1 of 6 sets of smoke/fire barrier doors would close to form a smoke resistant barrier. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 02/19/25 between 1:45 p.m. and 4:00 p.m. during a tour of the facility with the Executive Director from a sister facility, Senior Maintenance Director, and Director of Plant	K 0374	**K374** **No resident identified as being affected** **How the facility identified other residents: No residents were identified as being affected. The smoke door was immediately fixed by the senior mtc. director.** **Measures put into place/ System changes: Issue #1- Maintenance director reviewed components of K 374. Staff were in serviced and educated.** **How the corrective actions will be monitored:**	03/18/2025

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	Operations from a sister facility, the set of smoke barrier/fire barrier doors leading into the Therapy gym from the southeast corridor (near rooms 27 and 28) did not close completely when tested several times. There remained a one foot gap between the doors when closed to their fullest. This was acknowledged by the Senior Maintenance Director and Director of Plant Operations at the time of observation. The Director of Plant Operations acknowledged an airflow issue as to why the set of smoke/fire doors would not close completely. This finding was reviewed with the Executive Director from a sister facility, Senior Maintenance Director, and Director of Plant Operations from a sister facility during the exit conference. 3.1-19(b)		**Maintenance Supervisor/designee will monitor through facility preventative maintenance manual annually, any identified issues will be immediately corrected to ensure compliance. An audit tool was put in place to audit smoke barrier doors 3 x a week for the next 6 months.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 3/18/25**	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 1 of over 10 wet locations, was provided with ground fault circuit interrupter (GFCI) protection against electric shock. 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. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on	K 0511	**K511: Utilities- Gas and Electric** **The facility requests paper compliance for this citation.*This Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.***	03/18/2025

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	feeders. (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 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		***The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*****1)Immediate actions taken for those residents identifiedNo resident was found to be affected by the finding.2)How the facility identified other residents:Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice3) Measures put into place/ System changes:The electric receptacles in the beauty shop was repaired immediately.** Staff were educated and in serviced on this deficiency. **4)How the corrective actions will be monitored:The Maintenance Director/designee will audit 5 electrical receptacles weekly to ensure proper integrity and functional status for 6 months. The audit will be reviewed in Quality Assurance Meeting monthly to ensure no changes or until 100% of education has been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** Date of Compliance 3/18/25	

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	facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect at least one resident and one staff. Findings include: Based on observations on 02/19/25 between 1:45 p.m. and 4:00 p.m. during a tour of the facility with the Executive Director from a sister facility, Senior Maintenance Director, and Director of Plant Operations from a sister facility, there was a double electric receptacle on the left side of the hair washing sink in the Beauty Shop. The left side of the double receptacle was provided with a GFCI receptacle, however, when tested with a GFCI testing device the receptacle did not break the electrical circuit. Furthermore, the push buttons on the GFCI receptacle would not test or reset. Based on interview at the time of observation, the Executive Director agreed the receptacle in the Beauty Shop was not properly GFCI protected. This finding was reviewed with the Executive Director from a sister facility, Senior Maintenance Director, and Director of Plant Operations from a sister facility during the exit conference. 3.1-19(b)			

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K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to ensure 5 of 12 fire drill reports included complete and accurate documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months, or was documented during the correct staff shift. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 02/19/25 between 10:15 a.m. and 1:45 p.m. with the Executive Director from a sister facility, Senior Maintenance Director, and Director of Plant Operations from a sister facility present, the following fire drill reports were not provided with documentation for the transmission of the alarm to the monitoring company, or the fire alarm system was not activated in close time proximity with the fire drill performed, or was documented during the correct staff shift: a. 06/11/24 @ 4:00 a.m. on third shift - alarm activated on 06/28/24 b. 07/18/24 @ 4:26 p.m. was documented as a first shift fire drill. Based on interview, the Senior Maintenance Director said the first shift fire drills are to be performed between 7:00 a.m. and 3:00 p.m. c. 08/08/24 @ 4:30 p.m. on the second shift - No documentation of alarm transmission to the monitoring company d. 09/27/24 @ 4:50 a.m. on the third shift - No documentation of alarm transmission to the	K 0712	Deficiency ID: K _0712 1.)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified as being affected by the alleged deficient practice. 2.)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. The Maintenance Director will schedule fire drills to be held on unexpected days at unexpected times under varying conditions and get the transmission sheet by the next day and bring to morning meeting. 3.)What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The Maintenance Director or designee will monitor the fire drill schedule to ensure that fire drills are held on unexpected days at unexpected times under varying conditions and get the transmission sheet and bring to QA monthly. Staff were educated and in serviced on this deficiency. 4.)How the corrective actions will	03/18/2025

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	monitoring company e. 12/31/24 @ 2:30 a.m. on the third shift - alarm activated on 12/22/24 Based on interview at the time of record review, the Senior Maintenance Director confirmed 5 of the 12 fire drills conducted during the past 12 month period were lacking information verifying the transmission of the alarm was received by the monitoring company, not in close time proximity with the activation of the fire alarm system, or documented during the correct shift the fire drill was performed. This finding was reviewed with the the Executive Director from a sister facility, Senior Maintenance Director, and Director of Plant Operations from a sister facility during the exit conference. 3-1.19(b) 3.1-51(c)		be monitored to ensure the deficient practice does not recur. The Executive Director or designee will audit fire drills and transmission report monthly X 6 months to ensure fire drills are held on unexpected days at unexpected times and under varying conditions with any issues reported at the monthly QAPI meeting. 5.) Date of Completion 3/18/25	
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 1 of 1 oxygen room fire door assembly was completed in accordance with 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	K 0761	Deficiency ID: K _ 0761 K761 SS = F Maintenance, Inspection & Testing - Doors The facility requests paper compliance for this citation. This plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the	03/18/2025

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	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 at least 10 residents, as well as staff, and visitors.		facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: No resident or staff were found to be affected by the deficiency. 2) How the facility identified other residents: Residents that reside at the community have the potential to be affected by the alleged deficient practice. 3) Measures put into place/ System Changes: The Maintenance Director/designee will ensure annual door assembly inspections are completed and documentation of inspection is in the facility according to LSC. Staff were educated and in serviced on this deficiency. 4) How the corrective actions will be monitored: The Maintenance Director/designee will present the Door inspections to the QAPI	

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	Findings include: Based on record review on 02/19/25 between 10:15 a.m. and 1:45 p.m. with the Executive Director from a sister facility, Senior Maintenance Director, and Director of Plant Operations from a sister facility present, the facility was unable to provide documentation for an annual inspection of the oxygen transfilling room fire door assembly for the past 12 month period or prior. Based on interview at the time of record review, the Senior Maintenance Director said there was no documentation of an annual inspection of the oxygen transfilling room fire door assembly available to review for the past 12 month period. Based on observations during a tour of the facility between 1:45 p.m. and 4:00 p.m., there was one oxygen transfilling room fire door assembly noted in the facility. This finding was reviewed with the Executive Director from a sister facility, Senior Maintenance Director, and Director of Plant Operations from a sister facility during the exit conference. 3.1-19(b)		Committee during QAPI Meetings to ensure completion and compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 3/18/25	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Based on observation and interview, the facility failed to ensure cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 1 oxygen storage/transfilling room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.3 states storage for nonflammable gases with a total volume equal to or less than greater than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1 and 11.3.3.2. NFPA 99,	K 0923	Deficiency ID: K _ 0923 **K923 SS = E Gas Equipment – Cylinder and Container Storage** **The facility requests paper compliance for this citation.** *This plan of correction is the center's credible allegation of compliance.*	03/18/2025

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	Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect at least 20 residents, staff, and visitors. Findings include: Based on observations on 02/19/25 between 1:45 p.m. and 4:00 p.m. during a tour of the facility with the Executive Director from a sister facility, Senior Maintenance Director, and Director of Plant Operations from a sister facility, there were four "E" sized oxygen cylinders freestanding on the floor, and one "E" sized oxygen cylinder laying on the floor in oxygen storage/transfilling room. All five oxygen cylinders were not supported in a proper cylinder stand or otherwise secured from falling. Based on interview at the time of observation, the Senior Maintenance Director and Director of Plant Operations acknowledged the five oxygen cylinders freestanding or laying on the floor and not supported in a cylinder stand or otherwise secured from falling. This finding was reviewed with the Executive Director from a sister facility, Senior Maintenance Director, and Director of Plant Operations from a sister facility during the exit conference. 3.1-19(b)		*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** · No resident was found to be affected by the finding. **2) How the facility identified other residents:** · Visitors, staff, and residents have that reside at the community have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · Facility has removed the oxygen cylinder. An Audit was completed throughout the whole house to ensure no other oxygen cylinders had been stored improperly. No other was located. **4) How the corrective actions will be monitored:** · The Maintenance Director/designee will audit 1 O2 Rooms if present are stored correctly for 6 months. The audit will be reviewed present in QAPI Meetings to ensure completion and compliance. Staff were educated and in serviced on this	

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			deficiency. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 3/25/25**	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms where oxygen transfilling takes place, was provided with a door that closed completely and latched. This deficient practice could affect up to 20 residents, staff and visitors. Findings include: Based on an observations on 02/19/25 between 1:45 p.m. and 4:00 p.m. during a tour of the facility with the Executive Director from a sister facility, Senior Maintenance Director, and Director of Plant Operations from a sister facility, the oxygen storage/transfilling room door failed to fully close and positively latch into the frame when tested. Based on interview at the time of observation, the Senior Maintenance Director and Director of Plant Operations acknowledged the oxygen storage/transfilling room door did not close completely and latch when tested. This finding was reviewed with the Executive Director from a sister facility, Senior Maintenance	K 0927	**K927** **The facility requests paper compliance for this citation. Immediate actions taken latch for the door was immediately fixed. Maintenance Director or designee will audit doors weekly x 3 to ensure that the doors latch.** **2) How the facility identified other residents: No residents were identified as being affected.** **Measures put into place/ will audit random 3 doors randomly 3 x a week to ensure doors latch. Will bring to monthly QA and will be reviewed for 6 months.** **How the corrective actions will be monitored: Maintenance Supervisor/designee will monitor through facility**	03/18/2025

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	Director, and Director of Plant Operations from a sister facility during the exit conference. 3.1-19(b)		**preventative maintenance quarterly any identified issues will be immediately corrected to ensure compliance.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 3/18/25**	