STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155689	A. BUILDING -- B. WING	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	2400 COLLEGE AVE GOSHEN, IN 46526

(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: 03/26/24 Facility Number: 000091 Provider Number: 155689 AIM Number: 100290080 At this Emergency Preparedness survey, Majestic Care of Goshen was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 186 certified beds. At the time of the survey, the census was 120. Quality Review completed on 04/03/24	E 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the low scope and severity of these findings we respectfully request a desk review in lieu of a traditional revisit.**	
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 Dates: 03/26/24 Facility Number: 000091 Provider Number: 155689 AIM Number: 100290080 At this Life Safety Code survey, Majestic Care of Goshen was found not in compliance with	K 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the low scope and severity of these findings we respectfully request a desk review in lieu of a traditional revisit.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Caley Nixon	Executive Director	05/14/2024

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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	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) 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 and in areas open to the corridors. The resident rooms are provided with single station, hard wired smoke detectors. The building is partially protected by two 200 kW natural gas powered emergency generators. The facility has a capacity of 186 and had a census of 120 at the time of this survey. All areas where residents have customary access were sprinklered. The facility had a storage shed on the roof that was sprinklered, and two detached storage sheds that were not sprinklered. Quality Review completed on 04/03/24			
K 0161 SS=E Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story			

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	non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. Based on observation and interview, the facility failed to maintain the building type of V(111) by ensuring through penetrations in 1 of 1 one-hour fire ceiling barrier assemblies were maintained to ensure the fire resistance of the two-hour barrier. LSC 8.3.5.1 requires penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through	K 0161	**K161 – Building Construction Type and Height** It is the practice of this facility to ensure through penetrations in 1 of 1 one-hour fire ceiling barrier assemblies were maintained to ensure the fire resistance of the two-hour barrier. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** 1 The two-inch unsealed	04/26/2024

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	Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Fire Stops. This deficient practice affects 30 residents in one smoke compartment. Findings include: Based on observations Maintenance Director on 03/26/24 at 11: 30 a.m. in the Cedar electrical room there was an unsealed two-inch penetration around wires in the one-hour ceiling fire barrier. Based on interview at the time of observation, the Maintenance Director agreed the ceiling fire barrier was not maintained as a one-hour barrier due to the unsealed hole through ceiling fire barrier. The finding was reviewed with the Maintenance Director and the Administrator at the exit conference. 3.1-19(b)		penetration around wires in the one-hour ceiling fire barrier in Cedar electrical room had foam cleaned out and replaced with fire caulk. **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 on Cedar wing have the potential to be affected by this deficient practice. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Environmental team will be in-serviced on or before 4/17/2024. This in-service will be conducted by the Executive Director or Designee and will include a review of fire barriers and penetrations. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months.	

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 04/26/2024** Compliance Date = 04/26/2024	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING			

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	Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS			

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	LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 2 of 12 delayed egress locks was readily accessible for all residents, staff, and visitors. LSC 7.2.1.6.1.(3)(4) states a readily visible, durable sign in letters not less than 1 in. (25mm) high and not less than 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect 60 residents on D and C wings. Findings include: Based on observations with the Maintenance Director and Administrator on 03/26/24 between 11:00 a.m. and 1:00 p.m., the exit doors located on B-wing and the Garden Room were provided with delayed egress locks but lacked the proper signage indicating the doors can be opened in 15 seconds by pushing on the doors. Based on interview at the time of observation, the Maintenance Director agreed the doors were	K 0222	**K222 – Egress Doors** It is the practice of this facility to ensure all delayed egress locking arrangements are installed and functioning properly. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** 1 B wing exit doors have been supplied with the appropriate signage to indicate the doors can be opened in 15 seconds by pushing on the doors 2 Garden Room exit doors have been supplied with the appropriate signage to indicate the doors can be opened in 15 seconds by pushing on the doors **How other residents having the potential to be affected by the same deficient practice will be**	04/17/2024

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	equipped with a delayed egresses and lacked the proper signage. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		**identified and what corrective action(s) will be taken:** All residents on D and C wing have the potential to be affected by this deficient practice. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 4/17/2023. This in-service will be conducted by the Maintenance Director or Designee and will include a review of egress doors and proper signage . The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored	

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			though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 04/17/2023** Compliance Date = 04/17/2023	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in			

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	REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	1.) Based on observation and interview, the facility failed to ensure 2 of 10 hazardous rooms that contained fuel fired equipment were separated from other spaces by smoke resistant partitions. This deficient practice could affect 40 residents in two smoke compartments. Findings include: Based on observations with the Maintenance Director and Administrator on 03/26/24 between 11:00 a.m. and 1:00 p.m., in the laundry room behind the dryers and in the boiler room both ceilings contained holes and unsealed penetrations from 1 inch to 5 inches in size. Based on an interview at the time of the observation, the Maintenance Director agreed there were unsealed penetrations in the two rooms which contained fuel fired equipment. 2.) Based on observation and interview, the facility failed to ensure 1 of 1 rooms greater than 50 square feet and being used for storage of large	K 0321	**K321- Hazardous Areas** It is the practice of this facility to ensure all hazardous rooms that contain fuel fired equipment are separated from other spaces by some resistant partitions. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** 1 Laundry room behind the dryers and in the boiler room holes in ceiling foam removed and replaced with drywall and mud. 2 Room used for storage on B wing has been cleaned out and hinges replaced with automatic closing devices. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	04/26/2024

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	amounts of combustibles was protected as a hazardous area. This deficient practice could affect 40 residents in B-wing. Findings include: Based on observations with the Maintenance Director and Administrator on 03/26/24 at 11:55 a.m., the PPE storage room on B-wing contained over 100 boxes of supplies, was greater than 50 square feet, therefore making the room a hazardous area. The PPE room was not protected as a hazardous area because the corridor door to the room was not self-closing or automatic closing. Based on interview at the time of observation, the Maintenance Director agreed the PPE room contained large amount of combustible storage, was larger than 50 square feet, and the corridor door to the room was not self-closing. The findings were reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		**action(s) will be taken:** All residents have the potential to be affected by this deficient practice. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 4/17/2024. This in-service will be conducted by the Maintenance Director or Designee and will include a review of egress doors. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The	

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			Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 04/26/2024** Compliance Date = 04/26/2024	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be			

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	enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to properly install and maintain equipment protected by 1 of 1 kitchen hood extinguishing systems. LSC 9.2.3 states cooking equipment shall be in accordance with NFPA 96. NFPA 96 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, unless such installations are approved existing installations, which shall be permitted to be continued in service, and have an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. Section 10.1.2 states cooking equipment that produces grease-laden vapors and that might be a source of ignition of grease in the hood, grease removal device, or duct shall be protected by fire-extinguishing equipment. The deficient practice affects staff in the kitchen and 50 residents in the main dining room. The findings include: Based on observation with the Maintenance Director and Administrator on 03/26/24 at 12:43 p.m., the cooking equipment was not properly covered by the suppression due to the wheeled gas-fired six (6) burner range located on the cooking line in the kitchen was not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for	K 0324	**K324 – Cooking Facilities** It is the practice of this facility to ensure all equipment is properly installed and maintained. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The gas six-fire burner range was properly placed under the fire suppression system. **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 and staff in kitchen have the potential to be affected by this deficient practice. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	04/17/2024

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	155689	A. BUILDING 01 B. WING	03/26/2024

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	maintenance and cleaning. Based on interview during observation, the Maintenance Director agreed the cook top was not in the correct position for complete fire suppression and stated the kitchen was not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		All kitchen will be in-serviced on or before 4/17/2024. This in-service will be conducted by the Maintenance Director or Designee and will include a review of equipment placement and fire suppression systems. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic**	

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			changes will be completed: 04/17/2024 Compliance Date = 04/17/2024	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1.) Based on record review and interview, the facility failed to maintain 1 of 1 automatic sprinkler systems. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 5.3.4.1.2 states the concentration of antifreeze solution shall be limited to the minimum necessary for the anticipated minimum temperature. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority	K 0353	**K353 – Sprinkler Systems – Maintenance and Testing** It is the practice of this facility to maintain sprinkler systems and ensure all automatic sprinkler systems shall be inspected and maintained. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** 1 All sprinklers have been	05/21/2024

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	having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of the facility's annual sprinkler system inspection report with the Maintenance Director and Administrator on 03/26/24 at 10:28 a.m., the annual sprinkler report dated 02/08/24 showed the low testing point for the antifreeze was -1 degrees Fahrenheit. The reference section in NFPA Annex Figure A.5.3.4.1 Isothermal Lines - Lowest One-Day Mean Temperature (Fahrenheit.) showed the mean lowest temperature for the facility was at -10 Fahrenheit. Based on an interview at the time of record review, the Maintenance Director agreed the antifreeze was tested at -1 degrees and stated their area can get below -1 degrees in the winter. 2.) Based on observation and interview, the facility failed to replace 2 of 2 sprinkler heads in areas with moisture and 2 of 6 sprinkler heads in the laundry room in accordance with LSC 9.7.5. 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 staff in the service hall and 50 residents in the dining room.		placed on a monthly inspection and documentation schedule in TELS. 2 All sprinkler heads have been inspected and sprinkler vendor scheduled replacement on 05/21/24. 3 All testing has been reviewed with vendor and additional inspection and correction scheduled for 05/21/2024. **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 by this deficient practice. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 4/17/2024. This in-service will be conducted by the Maintenance Director or Designee and will include a review of egress doors. The Maintenance Director/Designee will be responsible for completing QAPI	

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	Findings include: Based on observations with the Maintenance Director and Administrator on 03/26/24 between 11:00 a.m. and 1:00 p.m., the following sprinkler heads showed signs of corrosion or loading, a) Two sprinklers in the kitchen dish room showed signs of corrosion. b) Two sprinkler heads in the laundry room by the dryers were loaded with dirt and lint. Based on interview at the time of observation, the Maintenance Director confirmed the aforementioned sprinkler heads showed signs of loading and corrosion. The findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 05/21/24.** Compliance Date = 05/21/24.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment			

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	complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1.) Based on observation and interview, the facility failed to ensure 2 of 2 receptacles within 6 feet from a sink 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. 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, (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. (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. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have 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 30 residents on B-wing.	K 0511	**K511 – Utilities – Gas and Electric** It is the practice of this facility to ensure all receptacles within 6 feet from a sink are provided with GFCI protection against electrical shock. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** 1 The B-wing spa and shower/storage room receptacles have been replaced with GFCI protected receptacles and tested. 2 The electrical wires and splices were removed and hole filled. 3 The electrical outlet in dining storage room has been replaced with a cover. **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 by this deficient practice. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month,	04/17/2024

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	Findings include: Based on observations with the Maintenance Director and Administrator on 03/26/24 between 11:00 a.m. and 1:00 p.m., in the B-wing spa and shower/storage room there were electric receptacles about 29 inches from a sink. Both electric receptacles were not GFCI protected, this was confirmed when the receptacles were tested. Based on interview at the time of observation, the Maintenance stated both electric receptacles were not GFCI protected when tested. 2.) Based on observation and interview, the facility failed to ensure 1 of 1 electrical splices in the boiler room were made in a junction box. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. Article 322.56 (A) states splices shall be made in listed junction boxes. This deficient practice could affect 15 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director and Administrator on 03/26/24 at 1:00 p.m., in the boiler room there were wires hanging from the ceiling with exposed copper ends and the wires were not contained inside a junction box. Based on interview at the time of the observations, the Maintenance Director acknowledged there were bare electrical wires that were not protected with a junction box. 3.) Based on observation and interview, the facility failed to ensure 1 of 1 electrical outlets in the dining storeroom contained a cover plate and		2x/week for the second month, and weekly for at least 6 months. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 4/17/2024. This in-service will be conducted by the Maintenance Director or Designee and will include a review of Electrical Outlets. The Maintenance Director/Designee will be responsible for completing QAPI audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. If 100% compliance is	

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	was protected from damage. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect 55 residents in the main dining room. Findings include: Based on observations with the Maintenance Director and Administrator on 03/26/24 12:40 p.m., in the dining storeroom had an electrical outlet with missing cover plates and exposing metal terminals. Based on an interview at the time of observation, the Maintenance Director agreed an outlet was missing the cover plate and there were electrical contacts visible. The findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 04/17/2024** Compliance Date = 04/17/204	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation, and interview; the facility failed to ensure 1 of 1 fire damper systems were inspected and provided necessary maintenance after the first year after	K 0521	**K521 - HVAC** It is the practice of this facility to ensure the fire dampers in the facility are inspected and provided	04/17/2024

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	instillation and at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents. Findings include: Based on records review with the Maintenance Director and Administrator on 03/26/24 at 10:10 a.m., no documentation was provided to show if the building's smoke/fire dampers have ever been inspected. Based on observation with the Maintenance Director between 11:00 a.m. and 2:00 p.m., there were smoke/fire dampers in the duct work by the smoke and fire barriers. Based on an interview at the time of records review and observations, the Maintenance Director stated the damper inspection could not be found and did not		necessary maintenance. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Vendor was contacted for additional fire damper inspection and supporting documentation on previous fire damper inspections provided. **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 by this deficient practice. The Maintenance Director/Designee will be responsible for ensuring damper inspections are properly scheduled and documented through TELS. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months to include TELS review.	

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	know if the dampers were ever inspected. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 04/17/2024** Compliance Date = 04/17/2024	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life			

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	safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview the facility failed to ensure 2 of 2 emergency generators had a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 Edition, 5.1. LSC Section 9.1.3.1 states emergency generators shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS):	K 0918	**K918 – Electrical Systems – Essential Electric Systems** It is the practice of this facility to ensure emergency generators have a reliable source of fuel. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The emergency generator vendor	04/17/2024

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	(1) Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. A.5.1.1 states examples of probability of interruption could include the following: earthquake, flood damage, or a demonstrated utility unreliability. This deficient practice had the potential to affect all residents. Findings include: Based on records review with the Maintenance Director and Administrator on 03/26/24 at 10:45 a.m., no letter of reliability for the facility's two natural gas generators was provided for review. Based on an interview during records review, the Maintenance Director stated the natural gas reliability letter could not be found. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		was contacted and provided a letter of liability for the facilities two nature gas generators. **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 by this deficient practice. The Maintenance Director/Designee will be responsible for reviewing TELS monthly to ensure that the letter of liability is current for the emergency generators. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director/Designee will be responsible for reviewing TELS monthly to ensure that a letter of liability is current for the emergency generators. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance	

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	155689	A. BUILDING 01 B. WING	03/26/2024

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			Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “TELS” weekly for 4 weeks and monthly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 04/17/2024** Compliance Date = 04/17/2024	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used			

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	temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 extension cords and 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw or met the UL rating of 1363A or 60601-1 in patient care locations according to LSC/2012 chapter 19 and NFPA-70/2011, 400.8. This deficient practice could affect 4 residents. Findings include: Based on observations with the Maintenance Director and Administrator on 03/26/24 between 11:00 a.m. and 1:00 p.m., the following areas had improper use of power strips and extension cords: A.) In room 207 an extension cord was used to power the resident ' s computer equipment. B.) In room 228 a power-strip that did not meet 1363A or 60601-1 was used to power the resident ' s electronics. Based on interview at the time of observation, the Maintenance Director Agreed an extension cord and a power-strip not meeting 1363A or 60601-1 was used in a patient care area. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)	K 0920	**K920 – Electrical Equipment – Power Cords and Extensions** It is the practice of this facility to ensure extension cords and power strips are not used as a substitute for fixed wiring to provide power to equipment. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** 1 Extension cord in room 207 was removed and replaced with appropriate power source. 2 Power strip in room 228 was removed and replaced with appropriate power source. **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 by this deficient practice. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months which will include checks for various rooms and office to ensure	04/17/2024

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			compliance with extension cords and power strips. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 4/17/2024. This in-service will be conducted by the Maintenance Director or Designee and will include a review of extension cords and power strip usage. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. If 100% compliance is	

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			not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 04/17/2024** Compliance Date = 04/17/2024	