STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING -- B. WING	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF TIPTON SKILLED NURSING FACILITY, THE	300 FAIRGROUNDS RD TIPTON, IN 46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/15/25 Facility Number: 000505 Provider Number: 155556 AIM Number: 100266350 At this Emergency Preparedness survey, The Waters of Tipton Skilled Nursing Facility was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 150 and had a census of 88 at the time of this survey. Quality Review completed on 04/21/25 The requirement at 42 CFR Subpart 483.73 is NOT MET as evidenced by:	E 0000	Preparation and or execution of this plan of correction in general, or this corrective action , does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not	E 0039	It is the intent of the facility to ensure to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures to meet set standards. 1. On 05-09-2025 the Administrator and the	05/09/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Waymire	Administrator	05/07/2025

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	accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness Policy Manual" documentation dated 12/05/24 with the Administrator and the Maintenance Director at 12:57 p.m. on 04/15/25, documentation for a full-scale exercise that is community-based or an individual, facility-based functional exercise within the most recent two year period was not available for review. The facility also did not document any actual natural or man-made emergency that required activation of the		DON/Maintenance Supervisor/designee conducted a full scale exercise that was community based or an individual facility-based functional exercise and documented the information on the after-action report and in the Life Safety Binder to meet set standards. 2. All residents and all staff and visitors have the potential to be affected but none were. 3. On 04-29-2025 the Administrator in serviced the DON/ Maintenance Supervisor/designee on the requirement to conduct annual exercises to include a community or facility based exercise and document on the after-action report and in the Life Safety Binder to meet set standards. !--[endif]-->DON/Maintenance Supervisor/designee will work with the Administrator to ensure annual exercise to include community based and record on the after-action report to meet set standards. If any issues are discovered, they will be addressed and resolved immediately. /p> 4. a.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator and the Administrator will present the inspection results at the monthly Quality Assurance/Performance	

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	emergency plan within the most recent two year period. Based on interview at 12:57 p.m. on 04/15/25, the Administrator agreed emergency preparedness testing documentation was not available for review at the time of the survey. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference.		Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/15/25 Facility Number: 000505 Provider Number: 155556 AIM Number: 100266350 At this Life Safety Code survey, The Waters of Tipton Skilled Nursing Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility was determined to be of Type V (111) construction and was fully sprinklered except for the attic above the second floor which consisted of noncombustible construction. The facility has a fire alarm system	K 0000	Preparation and or execution of this plan of correction in general, or this corrective action , does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.	

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	with smoke detection in the corridor and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 150 and had a census of 88 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except for one detached storage barn which was not sprinklered. Quality Review completed on 04/21/25			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Based on observation and interview, the facility failed to ensure 1 of 4 means of egress on the second floor was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 10 residents, staff and visitors if needing to exit the facility from the second floor. Findings include: Based on observations with the Maintenance Director during an initial walk through of the facility at 9:40 a.m. on 04/15/25, four resident beds were stored in the second floor corridor outside resident sleeping Room 84. Based on observations with the Maintenance Director at 2:26 p.m. on 04/15/25, the four resident beds were still stored in the second floor corridor outside resident sleeping Room 84 with each bed projecting into the more than half of the width of the corridor. Based on interview at 2:26 p.m. on 04/15/25, the Maintenance Director agreed the aforementioned means of egress was not	K 0211	It is the intent of the facility to ensure to provide means of egresses that are continuously maintained free of obstructions to full use in case of emergency to meet set standards. 1. On 04-24-2025 the Maintenance Supervisor/designee removed the four resident beds from the second floor corridor outside resident sleeping room 84 to meet set standards. The Administrator verified the work on 04-30-2025. 2. All residents and all staff and visitors have the potential to be affected but none were. 3. On 04-29-2025 the Administrator in-serviced the Maintenance Supervisor/designee and all other staff on the requirement to ensure corridor	05/09/2025

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	continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		means of egress are continuously maintained to meet set standards.. Maintenance Supervisor/all staff will ensure corridor means of egress are continuously maintained as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 4. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	

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K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on observation and interview, the facility failed to maintain the fire alarm system to ensure that it had accurate time and date information in accordance with the requirements of NFPA 101, 2012 edition, Sections 19.3.4 and 9.6 and NFPA 72, 2010 edition, Sections 14.1 and 14.1.1. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director at 2:09 p.m. on 04/15/25, the main fire alarm control panel in the first floor electrical room read the time of day as 1:19 p.m. at 2:09 p.m. Based on interview at 2:09 p.m. on 04/15/25, the Maintenance Director agreed the main fire alarm system control panel for the facility displayed the incorrect time of day. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0345	It is the intent of the facility to ensure to maintain the fire alarm system to ensure it has accurate time and date information in accordance with the requirements of NFPA 101, 2012 edition, sections 19.3.4 and 9.6 and NFPA 72, 2010 edition, Sections 14.1 and 14.1.1 to meet set standards. 1. On 04-28-2025 the facilities licensed fire alarm contractor/maintenance supervisor/designee made repairs to the main fire alarm system control panel in the first floor electrical room and corrected the time of day to meet set standards. The Administrator verified the work on 04-30-2025. 2. a.All residents and all staff and visitors have the potential to be affected but none were. /p> 3. On 04-29-2025 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure proper maintenance of the fire alarm system to meet set standards.Maintenance Supervisor/Licensed Fire Alarm Contractor/designee will ensure proper maintenance of the fire alarm system as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate.	05/09/2025

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			If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Based on observation and interview, the facility failed to ensure 1 of 1 therapy rooms were separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment	K 0361	It is the intent of the facility to ensure therapy rooms are separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an exception per 19.3.6.1(7) to meet	05/09/2025

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	rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Therapy Room on the first floor. Findings include: Based on observations with the Maintenance Director at 1:48 p.m. on 04/15/25, the corridor door set to the Therapy Room across from the Laundry Room was not equipped with a positive latching mechanism to latch each door in the door set into the door frame. The corridor door set served as 1 of 3 entrances to the Therapy Room and was not equipped with any latching hardware. Based on interview at 1:48 p.m. on 04/15/25, the Maintenance Director agreed the corridor door set to the Therapy Room was not equipped with positive latching devices to secure the door set into the door frame and to ensure the treatment room was not open to the corridor. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		set standards. 1. On 04-29-2025 the Maintenance Supervisor/designee installed positive latching mechanism to each door in the door set to the Therapy Room across from the Laundry Room to meet set standards. The Administrator verified the repair on 04-30-2025. 2. All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee inspected all doors and found no other negative findings. 3. On 04-29-2025 the Administrator in serviced the Maintenance Supervisor/All staff on the requirement to ensure positive latching mechanisms are installed to the Therapy Room to meet set standards. !--[endif]-->Maintenance Supervisor/designee will ensure positive latching mechanisms are installed to the Therapy Room as a part of the facility's Monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. !--[endif]-->The Administrator will monitor adherence to the Preventative Maintenance	

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			schedule and validate the Preventative Maintenance documentation is in place. 2 The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this	K 0761	It is the intent of the facility to ensure an annual inspection and testing of all fire door assemblies is completed in accordance with LSC 19.1.1.4.1.1 to meet set standards. 1. On 07-23-2024 the certified fire door contractor/Maintenance Supervisor conducted the annual inspection of the rolling fire doors and documented the results in the Life Safety Binder to meet set standards. The Administrator verified the work on 04-30-2025. 2. All residents and all staff and visitors have the potential to be affected but none were.	05/09/2025

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	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, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. 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, Section 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		3. /a> !--[endif]-->Maintenance Supervisor/designee will ensure an annual inspection and testing of rolling fire doors is completed and documented as a part of the facility's annual Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. !--[endif]-->The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	

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	inspected to verify their presence and integrity. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the first floor dining room. Findings include: Based on record review with the Administrator and the Maintenance Director at 12:38 p.m. on 04/15/25, rolling fire door inspection and testing documentation within the most recent twelve month period was not available for review. Based on interview at 12:38 p.m. on 04/15/25, the Maintenance Director stated the facility has one rolling fire door in the kitchen and rolling fire door inspection and testing documentation within the most recent twelve month period was not available for review. The Maintenance Director stated there may be a hanging tag affixed to the rolling fire door by an inspection contractor but also stated it could have been removed. Based on observations with the Maintenance Director at 1:34 p.m. on 04/15/25, the facility has one rolling fire door in the kitchen separating the kitchen from the open dining room on the first floor in the first floor main entrance lobby smoke compartment. The dining room was open to the corridor. No inspection and testing documentation could be located on the rolling fire door. Based on interview at 1:34 p.m. on 04/15/25, the Maintenance Director agreed inspection and testing documentation for the rolling fire door in the kitchen within the most recent twelve month period was not available for review. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			

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K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Based on record review and interview, the facility failed to ensure documentation of electrical outlet receptacle testing for all resident sleeping rooms was completed in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all residents, staff and visitors. Findings include: Based on review of "Annual Receptacle Testing Log" documentation dated 01/01/25 for "General Care Areas (Annually)" with the Administrator and the Maintenance Director at 12:36 p.m. on 04/15/25, electrical receptacle inspection and	K 0914	It is the intent of the facility to ensure documentation of electrical outlet receptacle testing for all resident sleeping rooms is completed in accordance with NFPA 99 to meet set standards. 1. On 04-28-2025 the Maintenance Supervisor completed the annual resident room receptacle testing including itemizing the room location and the receptacle locations in each room to meet set standards. The Administrator verified the work 04-30-2025. 2. All residents and all staff and visitors have the potential to be affected but none were. 3. On 04-29-2025the Administrator in-serviced the Maintenance Supervisor/designee on the requirement the annual electrical receptacle testing must be completed annually and include itemizing the room location and the receptacle locations in each room and documented in the life safety binder to meet set standards. !--[endif]-->Maintenance Supervisor/designee will ensure the annual electrical receptacle testing must be completed annually and include itemizing the room location and the receptacle locations in each room as a part of the facility's annual Preventive	05/09/2025

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	155556	A. BUILDING 01 B. WING	04/15/2025

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	testing documentation for all resident sleeping rooms within the most recent twelve month period was incomplete. The 01/01/25 inspection and testing documentation did not itemize the room location and did not itemize receptacle locations in each room. The 01/01/25 inspection and testing documentation grouped resident sleeping rooms together under "Room Location" as "RM 1-12", "RM 13-28", "RM A & B", "RM 29-40", "RM 42-54", "RM 55-65", "RM 66-78" and "RM 79-90". Based on interview at 12:36 p.m. on 04/15/25, the Maintenance Director stated each resident sleeping room may have a mix of hospital grade and non-hospital grade receptacles installed in the room but agreed the 01/01/25 annual receptacle inspection and testing documentation was not itemized by receptacle location. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. !--[endif]-->The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.4 which requires emergency generators	K 0918	It is the intent of the facility to ensure to emergency generators are allowed a 5 minute cool down period after a load test to meet set standards.	05/09/2025

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	providing power to emergency lighting systems to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 2010 Edition, Section 6.2.10 Time Delay on Engine Shutdown requires a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown to allow for engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. NFPA 110, Section 8.3.4 states a permanent record of the Emergency Power Supply Systems (EPSS) inspections, tests, exercising, operation, and repairs shall be maintained and readily available. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator - Monthly Test Log" documentation for the most recent twelve month period with the Maintenance Director at 12:30 p.m. on 04/15/25, monthly load testing documentation for the facility's diesel fuel fired emergency generator did not include a cool down time for a minimum of 5 minutes. The monthly load test cool down time was consistently documented as "200 seconds" which is less than 5 minutes. Based on interview at 12:30 p.m. on 04/15/25, the Maintenance Director stated there has been no change to the length of the minimum cool down time for monthly load testing and agreed the documented cool down time was less than 5 minutes. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference.		1. On 04-28-2025 the Maintenance Supervisor/designee conducted the monthly load testing for the facility's diesel fuel fired emergency generator and included a 5 minute cool down time and documented the results in the Life Safety Binder to meet set standards. The Administrator verified the work on 04-30-2025. 2. All residents and all staff and visitors have the potential to be affected but none were. 3. On 04-29-2025 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure to conduct proper maintenance and testing of the emergency electrical generator including conducting the monthly load testing with a minimum cool down time of 5 minutes to meet set standards. !--[endif]-->The Maintenance Supervisor will ensure to conduct proper maintenance and testing of the emergency electrical generator including conducting the monthly load testing with a minimum cool down time of 5 minutes as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. The Administrator will monitor	

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	3.1-19(b)		adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review, observation and interview; the facility failed to conduct the required maintenance and maintain complete documentation of inspections for all Patient Care Related Electrical Equipment (PCREE). NFPA 99, Health Care Facilities Code, 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a	K 0921	It is the intent of the facility to ensure to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE) to meet set standards. 1. On 04-28-2025 the facilities trained Regional Property Managers will conduct PCREE testing on the other PCREE in the facility including: electric beds, nebulizers, oxygen concentrators, vital sign monitors, and other electrical medical equipment to meet set standards. The	05/09/2025

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	complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents in the facility. Findings include: Based on record review with the Administrator and the Maintenance Director at 12:37 p.m. on 04/15/25, PCREE testing documentation was not available for review. Based on interview at 12:37 p.m. on 04/15/25, the Maintenance Director agreed PCREE testing documentation was not available for review. Based on observations with the Maintenance Director at 1:07 p.m. on 04/15/25, the resident bed in Room 50 was an electric bed. Based on interview at 1:07 p.m. on 04/15/25, the Maintenance Director stated all resident beds in the facility are electric beds. Based on observation at 2:12 p.m. on 04/15/25, an oxygen concentrator was in use in resident Room 10. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		Administrator verified the work on 04-30-2025. 2. All residents and all staff and visitors have the potential to be affected but none were. 3. On 04-29-2025 the Administrator in serviced the Maintenance Supervisor/designee to ensure the testing of the PCREE is conducted and documented on all PCREE equipment to meet set standards. Maintenance Supervisor/designee will ensure testing of the PCREE is conducted and documented on all PCREE equipment as a part of the facility's annual Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting.	

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			Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	