STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155740	A. BUILDING -- B. WING	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TIMBERCREST CHURCH OF THE BRETHREN HOME	2201 EAST ST NORTH MANCHESTER, IN 46962

(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: 10/15/24 Facility Number: 000448 Provider Number: 155740 AIM Number: 100275140 At this Emergency Preparedness survey, Timbercrest Church of The Brethren Home was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 65 and had a census of 57 at the time of this survey. Quality Review completed on 10/21/24	E 0000		
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: 10/15/24 Facility Number: 000448 Provider Number: 155740 AIM Number: 100275140 At this Life Safety Code survey, Timbercrest Church of The Brethren Home was found not in compliance with Requirements for Participation in	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sabine	Thomas	11/15/2024

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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	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 the basement was determined to be of Type II (222). The facility was fully sprinklered, has a fire alarm system with hard wired smoke detection in the corridors, and areas open to the corridor. 16 resident rooms in the 300-hall and 400-hall with the exception of rooms 305, 306, and 406 were wired for power but were not connected to the fire alarm system. 30 battery operated smoke detectors were installed in the resident rooms on the 200-hall, 300hall, rooms 305, 306, and 406. The facility has a capacity of 65 and had a census of 57 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for a detached maintenance garage. Quality Review completed on 10/21/24			
K 0131 SS=E Bldg. 01	NFPA 101 Multiple Occupancies Based on observation, records review, and interview the facility failed to ensure the penetration in 1 of 1 fire barrier walls that separated health care from assisted living was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.3.5.1 requires penetrations for cables, cable	K 0131	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction.	11/08/2024

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	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 Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Fire Stops. This deficient practice could affect 30 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 10/15/25 at 2:00 p.m., above the ceiling tiles of the separation fire barrier to Assisted Living there was joint compound around a pipe sleeve and the end of the pipe was not sealed. Based on records review with the Maintenance Director at 2:30 p.m., there was no documentation to show if the joint compound meets ASTM 814. Based on interview at the time of observation, the Maintenance Director agreed joint compound was used to seal penetrations and the end of the pipe sleeve was not sealed. The findings were reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		This plan of correction is submitted as the facility's credible allegation of compliance. The identified problem was immediately remedied. A walkthrough of the health care unit was performed by the Director of Maintenance and no further discrepant findings. The policy "Inspection of Fire/Smoke Walls" was reviewed and maintenance staff is being re-educated on the policy and procedure by the Director of Maintenance. The Director of Maintenance/designee will inspect compliance of correct sealing of all penetrations of fire and smoke walls upon completion of work for compliance with code. The inspection will be continous pending determination of substantial compliance by the QAA committee.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through 1 of	K 0222	Preparation and/or execution of this plan do not constitute	10/21/2024

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	1 exit separation doors were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. This deficient practice could affect over 20 residents wanting to exit use the Crestwood exit. Findings include: Based on observation with the Maintenance Director on 10/15/24 at 1:40 p.m., in the hall leading to the Crestwood Memory Care unit which has residents with a clinical diagnosis requiring specialized security measures contained separation cross corridor doors, was marked as a facility exit, was magnetically locked, and could be opened with a key-FOB that was only carried by staff. This condition does not allow someone without a key-FOB to open the exit door during an emergency. Based on interview at the time of observation, the Maintenance Director agreed only staff had access to open the exit door to the Crestwood exit. The findings were reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. The door in question unlocks and opens after pushing on the crash bar for several seconds. It unlocks automatically upon loss of power and during a fire alarm. A sign was posted on door to instruct residents, staff, visitors to push in an emergent event.	
K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Based on record review and interview the facility failed to ensure the preventative maintenance for 30 of 30 battery operated smoke alarms in resident rooms was conducted according to manufacturer's	K 0300	The TELS generated workorder for all smoke detectors in the health care unit was immediately changed to weekly testing and	11/08/2024

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	published instructions. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect at least 30 residents. Findings include: Based on records review with the Maintenance Director on 10/15/24 at 11:30 a.m., the "Battery-Operated Smoke Detector Maintenance Log" for 2024 showed only monthly testing of the battery-operated smoke alarms and did not show weekly testing or cleaning. The manufacturer's published instructions for the smoke alarms stated: the alarms require weekly testing and cleaned monthly. Based on an interview during records review, the Maintenance Director stated the alarms are tested monthly, and agreed the alarms should be tested weekly and cleaned monthly according to manufacturer's published instructions. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference.		cleaning this to streamline the testing of all smoke detector. Maintenance staff was educated on the testing procedure and frequency, as well as cleaning of the smoke detectors. The housekeeping staff was educated on cleaning the smoke detectors. A schedule and sign off sheet has been implemented for tracking compliance. The Director of Housekeeping or designee will audit for compliance weekly x 8 weeks; then twice monthly for 2 months. Reports will be submitted to QAPI and to the QAA committee until such time consistent compliance has been achieved as determined by the committee.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities (#1.) Based on observation and interview, the facility failed to ensure staff were instructed in the	K 0324	Postings were placed in the kitchen and kitchen staff was	11/08/2024

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	use of the UL 300 hood system in 1 of 1 Kitchens. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. (#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. (#3.) Based on observation and interview, the facility failed to ensure staff had access to the shutoff switch for 1 of 1 cook tops in the therapy gym. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: Section 19.3.2.5.3(3) states The requirements of (3)		in-serviced on the operation of the fire extinguishing system immediately. Maintenance staff will be educated on the manual operation of this system as back up. This education piece has been added to the onboarding checklists for kitchen and maintenance staff. The Director of Dietary Services or designee will test kitchen staff monthly x 3 months. Markings for visual guidance of proper repositioning of equipment have been made on the floor; a description has been posted in the kitchen area accordingly. Kitchen staff and maintenance staff have been educated on the proper placement of the equipment and visual tool. Director Dietary Services or designee will monitor for compliance with proper positioning of equipment monthly x 3 months. The stove was immediately disconnected and the power cord removed. A conversation between facility administration and therapy provider is currently in process including issue of keeping the therapy kitchenette. Until conclusion, the stove remains permanently disabled.	

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	through (10) and (13) are met. Section 19.3.2.5.3(9) states a switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. (c) The switch is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. The deficient practices could affect 44 residents in the therapy gym and main dining room. Findings include: (#1.) Based on observation with the Maintenance Director on 10/15/24 at 1:15 p.m., the kitchen was provided with a UL 300 hood system and a K-class fire extinguisher with posted instructions. Based on an interview, the Cook was asked how to activate the hood suppression system if there was a grease fire underneath the hood. The Cook stated I do not know how to activate the suppression system. The Maintenance Director acknowledged the Cooks response and stated staff will need to be trained on the proper procedures for extinguishing a grease fire on the cooking equipment. (#2.) Based on observation with the Maintenance Director on 10/15/24 at 1:10 p.m., the cooking equipment in the main kitchen was covered by the fire suppression system, but 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			

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	moved for maintenance and cleaning. Based on interviews during observation, the Maintenance Director and Dietary Manager agreed 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. (#3.) Based on observation with the Maintenance Director on 10/15/24 at 12:44 p.m., there was an electric cooktop in the Therapy Room that was separated from the corridor, but staff were unable to deactivate the cooktop from electrical power. The cooktop was hardwired to breaker box without a shutoff switch on a timer . Based on interview at the time of the observations, the Maintenance Director agreed that a locked switch on a timer within the cooking area, or a switch on a timer located in a restricted location within the cooking area, was not provided within the cooking facility that deactivates the cooktop. The findings were reviewed with the Maintenance Director and the Administrator during the exit conference.			
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. (#1.) NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually	K 0345	The facility's fire alarm inspection company has been contacted immediately and regular visual inspection six months prior to the annual inspections has been scheduled. Visusal inspection will be performed in April 2025 and the annual inspection in October 2025. A Life Safety Schedule for the required inspections for the year will be implemented and	11/08/2024

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	inspected semi-annually: a. Control unit trouble signals. b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices (#2.) NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice affects all occupants in the facility. Findings include: (#1.) During records review with the Maintenance Director on 10/15/24 at 10:55 a.m., no documentation was provided regarding a visual inspection of the fire alarm system six months prior to the annual fire alarm inspection conducted on 08/22/24. Based on an interview at the time of records review, the Maintenance Director stated a visual inspection of the fire alarm system six months prior to the annual fire alarm inspection on 08/22/24 was not conducted. (#2.) During records review with the Maintenance Director on 10/15/24 at 10:00 a.m., the last fire system inspection dated 08/22/24 indicated that a duct detector device failed to report to the panel. Based on interview at the time of record review, the Maintenance Director confirmed the device failed testing and stated the device has not been replaced or repaired but has been scheduled for repair.		submitted to the Safety Committee for compliance review. The failed duct detector identified through the fire system inspection was replaced with new detector on 10/16/2024 by contractor. The new detector was tested and verified that it functioned properly and would shut down the appropriate systems. To ensure timely mitigation of future problems identified through fire system inspections, effective immediately, the Director of Maintenance will submit to the Safety Committee reports of all inspections for review. Future deficiencies noted through facility systems inspections will be reported to the Safety Committee and the QAPI committee for guidance.	

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	This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing (#1.) Based on observation and interview, the facility failed to ensure 1 of 2 sprinklers in the dish room were free of corrosion. 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. (#2.) Based on observation and interview, the facility failed to maintain the ceiling construction of 1 of 1 stairwells with roof access. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice affects 40 residents in two smoke compartments. Findings include: (#1.) Based on observation with the Maintenance Director on 10/15/24 at 1:20 p.m., the sprinkler	K 0353	The sprinkler heads were replaced by the contractor on 10/29/2024. The policy *Sprinkler System* has been reviewed. Staff is being re-educated on the policy and procedure. Effective immediately, the *Sprinkler System Inspection Log* and *Comment Sheet* shall be submitted to the Safety Committee for review and necessary action. The opening to roof was closed at ceiling level. The Director of Maintenance performed facility walk thru finding no other such openings in the health care unit.	10/29/2024

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	head at the front of the dish room was green and showed signs of corrosion. Based on an interview at the time of observation, the Maintenance Director agreed a sprinkler head in the dish room showed signs of corrosion. (#2.) Based on observation with the Maintenance Director on 10/15/24 at 1:50 p.m., in the Crestwood stairwell the ladder access opening to the roof which had a four-foot space between the ceiling and roof hatch did not have a cover at the ceiling level. This condition could delay the activation of the sprinklers installed on the ceiling. Based on an interview at the time of the observations, the Maintenance Director agreed there was not a hatch or cover around the ladder opening. The findings were reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)			
K 0355 SS=F Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on records review and interview, the facility failed to ensure 8 of 30 portable fire extinguishers that failed testing were repaired or replace. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition	K 0355	The failed fire extinguishers were replaced on 10/30/2024. In addition to the Director of Maintenance and the administrative staff for maintenance to review inspection reports, reports will be submitted to the Safety Committee to review for compliance. A report of future deficient findings will be submitted to the QAPI committee for recommendations.	10/30/2024

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	will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.2.3 Corrective Action states when an inspection of any fire extinguisher reveals a deficiency in any of the conditions listed in 7.2.2, immediate corrective action shall be taken. This deficient practice affects all residents. Findings include: Based on records review with the Maintenance Director on 10/15/24 at 10:20 a.m., the annual fire extinguisher inspection dated 12/22/23 indicated 8 fire extinguishers failed testing due to damage, needing 6-year inspection, or hydro testing. Also, there was no documentation indicating the extinguishers had been fixed or replaced. Based on an interview during records review, the Maintenance Director stated there was no paperwork to show if the 8 failed fire extinguisher were fixed or replaced and did scheduled service for end of October of 2024. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)			
K 0372 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation, records review, and interview the facility failed to ensure the penetration in 3 of 3 smoke barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC	K 0372	Corrective action to seal and penetrations with known correct caulk is in process. Additional areas noted per facility walk thru by the Director of Maintenance were added to workorder. The policy *Inspection of Fire/Smoke Walls* was reviewed	11/08/2024

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	155740	A. BUILDING 01 B. WING	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TIMBERCREST CHURCH OF THE BRETHREN HOME	2201 EAST ST NORTH MANCHESTER, IN 46962

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	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 Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Fire Stops. This deficient practice could affect all residents. Findings include: Based on observation with the Maintenance Director on 10/15/25 between 2:10 p.m. to 2:30 p.m. above the ceiling tiles of the 200, 300, and 400 smoke barriers contained unsealed penetrations around pipes and some penetrations were sealed with grey caulk with an unknown fire rating. Based on records review with the Maintenance Director at 2:40 p.m., there was no documentation to show if the grey caulk meets ASTM 814. Based on an interview at the time of observation, the Maintenance Director agreed grey caulk was used to seal penetrations with a unknown fire rating and there were unsealed penetrations in the smoke walls. The findings were reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		and maintenance staff is being re-educated on the policy and procedure by the Director of Maintenance. Effective immediately, the Director of Maintenance or designee will inspect work involving penetrations of fire and smoke walls for compliance with sealing and correct caulk upon completion of work.	
K 0712 SS=F	NFPA 101 Fire Drills			

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Bldg. 01	Based on record review and interview, the facility failed to conduct fire drills on each shift for 1 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on records review with the Maintenance Director on 10/15/24 at 11:36 a.m., no documentation was available to show if a third shift fire drill for the first quarter of 2024 was conducted. Based on an interview at the time of record review, the Maintenance Director stated the aforementioned drill was conducted on first shift and missed third shift. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	The Director of Maintenance has developed a chart to capture all departments with their varying staff schedules. This chart is used to ensure the required drills. The "Fire Drill Report" form was updated for listing shifts plus time of the drill. The schedule for drills will be submitted to the Safety Committee for review and to maintain compliance.	11/08/2024
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation, records review, and interview, the facility failed to maintain annual testing of 1 of 1 rolling fire door in accordance with NFPA 80. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition,	K 0761	The rolling fire door was inspected and found in compliance by the contractor on 10/17/2024. A sticker was affixed to the rolling fire door accordingly by the inspecting entity. The Director of Maintenance has reviewed the facility systems plan	11/08/2024

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	arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80 5.2.1 requires 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. This deficient practice could affect 40 residents in the main dining room. Findings include: Based on records review with the Maintenance Director on 10/15/25 at 10:09 p.m., the annual rolling fire door inspection in the kitchen was past due with a date of August of 2023. Based on observation at 12:50 p.m., there was a rolling fire door/window between the kitchen and dining room. Based on an interview at the time of observation, the Maintenance Director stated the fire door/window inspection was past due and service has been scheduled. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		with the fire system inspection provider and made necessary additions to have all required facility systems inspected by the fire safety provider. The updated worksheet will be submitted to the Safety Committee for review and acceptance. Future deficient findings through the fire systems inspection will be reported to the QAPI committee for recommendations.	
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 facility's diesel powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and	K 0918	The required polishing of the fuel was completed successfully on 11/06/2024. The fuel was tested prior to and after polishing to ensure the problem was mitigated. The final report of the polishing by the contracted provider will be submitted to the Safety Committee for review.	11/06/2024

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	Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on records review with the Maintenance Director on 10/15/25 at 10:27 a.m., the annual fuel quality test for the diesel generator conducted on 09/20/24 failed testing. Based on interview at the time of records review, the Maintenance Director agreed the fuel testing failed and stated the fuel polishing is scheduled for November 2024. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)			