STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING -- B. WING	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE KOKOMO	3518 S LAFOUNTAIN ST KOKOMO, IN 46902

(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: 10/01/24 Facility Number: 000025 Provider Number: 155064 AIM Number: 100274850 At this Emergency Preparedness survey, Aprion Care Kokomo was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 105 certified beds. At the time of the survey, the census was 55. Quality Review completed on 10/08/24	E 0000		
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418 Plan Based on All Hazards Risk Assessment Based on record review and interview, the facility failed to maintain an Emergency Preparedness Plan (EPP) that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants. Findings include:	E 0006	**E006** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or*	10/03/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deana Jordan Collins	Regional Nurse Consultant	10/22/2024

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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	Based on records review with the Maintenance Director on 10/01/24 at 10:45 a.m., the paperwork provided regarding a documented facility-based and community-based risk assessment utilizing an all-hazards approach was not filled out. Based on an interview at the time of record review, the Maintenance Director agreed the risk assessment utilizing an all-hazards approach provided for review was left blank. This finding was reviewed with the Director of Nursing, Assistant Director of Nursing, and Maintenance Director during the exit conference.		*executed solely because it is required by the provisions of federal and state law.* 1 How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No residents negatively affected. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. Facility will keep updated and completed hazard risk assessment in EOP binder. 3 What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur: Maintenance director and/or Administrator will review EOP binder monthly to make sure all assessments are accurate and filled out 4 How will the facility monitor its performance to make sure that solutions are sustained; the plan is implemented, and the corrective action evaluated for its	

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			effectiveness; and the plan of correction is integrated into the quality assurance system? Add it to environmental section of the monthly QAP to review The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 Date of compliance 10/03/24	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(EP Training Program Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR	E 0037	**E037** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or*	10/14/2024

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	483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Director of Nursing (DON) and the Maintenance Director on 10/01/24 at 10:11 a.m., initial EPP training for new hires was completed, but no documentation of annual EPP training or documentation to show existing staff could demonstrate knowledge of the EPP was available for review. Based on an interview at the time of records review, the Maintenance Director and the DON agreed annual EPP training for existing staff was not conducted within the last year. This finding was reviewed with the Director of Nursing, Assistant Director of Nursing, and Maintenance Director during the exit conference.		*executed solely because it is required by the provisions of federal and state law.* 1 How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No residents were negatively affected. New employees will be trained on emergency preparedness upon their orientation period. Existing employees will be trained annually. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. Training completed for current employees, all new employees will received training during orientation period. All employees will be trained annually. 3 What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur: The Maintenance Director has been delegated to lead the emergency preparedness training	

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			for new and existing employees. The Administrator will review this annually with the Maintenance Director 4 How will the facility monitor its performance to make sure that solutions are sustained; the plan is implemented, and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? The emergency preparedness training will be added to in-service as a recurring annual task. Human Resources will be monitoring to ensure new employees are receiving their emergency preparedness training. The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 Date of compliance 10/14/24	

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E 0039 SS=C Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the LTC facility failed analyze the facility's response to and maintain complete documentation of all Emergency Preparedness Program drills. 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 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 in a 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.	E 0039	**E039** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1 How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No residents affected. The facility will complete a full-scale community-based exercise and a tabletop EP exercise. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. The facility has completed tabletop EP exercise annually.	10/18/2024

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	Findings include: Based on records review with the Director of Nursing (DON) and the Maintenance Director on 10/01/24 at 11:11 a.m., documentation for the annual exercises conducted on 06/28/24 and on 06/28/24 was incomplete. Both exercises did not show the scenario of the exercise and if the facility's response was analyzed to ensure the staff followed the EPP to ensure the policies were effective. Based on an interview at the time of records review, the Maintenance Director stated no documentation for analyzing the LTC facility's response was completed. This finding was reviewed with the Director of Nursing, Assistant Director of Nursing, and Maintenance Director during the exit conference.		3 What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur: Add to in-service calendar as a recurring annual reminder to complete the training. Facility will conduct EP tabletop annually. 4 How will the facility monitor its performance to make sure that solutions are sustained; the plan is implemented, and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? Added to in-service as a recurring annual task. The Administrator will review this annually. The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and the Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 10/01/24 at 10:42 a.m., the generator lacked complete weekly inspections and the monthly load testing required by the LSC and NFPA 110. Based on interview at the time of record review, the Maintenance Director stated the generator was missing some of the required testing. This finding was reviewed with the Director of Nursing, Assistant Director of Nursing, and Maintenance Director during the exit conference.	E 0041	5 Date of compliance 10/18/24 **E041** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1 How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No residents were negatively affected. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected.	10/20/2024

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			Maintenance Director will complete weekly inspections and monthly load testing. 3 What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur: The Maintenance Director will complete and document weekly inspections and monthly load testing. The Administrator will review this weekly with the Maintenance Director 4 How will the facility monitor its performance to make sure that solutions are sustained; the plan is implemented, and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? The weekly inspection and monthly Inspection audit will be review during monthly safety committee meeting The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will	

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			identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 Date of compliance 10/20/24	
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: 10/01/24 Facility Number: 000025 Provider Number: 155064 AIM Number: 100274850 At this Life Safety Code survey, Aperion Care Kokomo was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery-operated detectors in all resident sleeping rooms. The facility has a capacity of 105 and had a census of	K 0000		

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	55 at the time of this survey. All areas where the residents have customary access were sprinklered. Quality Review completed on 10/08/24			
K 0211 SS=F Bldg. 01	NFPA 101 Means of Egress - General Based on observation and interview, the facility failed to ensure 3 of 3 resident corridors means of egress were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice affects all residents in the facility. Findings include: Based on observation with the Maintenance Director on 10/01/24 between 9:00 a.m. and 2:00 p.m., in all resident halls there were trashcans not equipped with wheels. The trash cans were observed by rooms, 103, 110, 115, 127, 211, 304, and 317. Based on an interview at the time of	K 0211	**K211** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1 How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No residents were negatively affected. Trashcans were removed from hallway. 2 How will the facility identify other residents having the potential to be affected by the	10/13/2024

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	observations, the Maintenance Director stated the trashcans at the aforementioned locations were not equipped with wheels and would need to be replaced with trash cans with wheels. The findings were reviewed with the DON, Assistant Director of Nursing, and the Maintenance Director at the exit conference. 3.1-19(b)		same deficient practice: All residents have the potential to be affected. A full facility assessment has been conducted ensuring there are no trashcans without wheels left in hallway outside of resident rooms. 3 What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur: The facility will conduct a full facility assessment once a month for 6 months. 4 How will the facility monitor its performance to make sure that solutions are sustained; the plan is implemented, and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? Facility Administrator will review monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive	

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			months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 Date of compliance 10/13/24	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Based on observation and interview, the facility failed to ensure 1 of 8 exit discharges were provided with an unobstructed level walking surface in accordance with NFPA 101 (2012 edition) section 7.7. This deficient practice could affect 25 residents that would use the southeast exit. Findings include: Based on observation with the Maintenance Director on 10/01/24 at 12:46 p.m., the southeast exit discharge had a concrete walkway leading to the common way. There was a 4ft x 4ft concrete square that contained mud holes due to deterioration of the concrete, and by the exit door there were patched cracks falling apart making the walkway uneven. Based on interview at the time of observation, the Maintenance Director agreed the walkway was in poor condition and did not provide an unobstructed level walking surface. This finding was reviewed with the Director of Nursing, Assistant Director of Nursing and the Maintenance Director at the exit conference.	K 0271	**K271** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1 How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No residents were negatively affected.	11/20/2024

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	3.1-19(b)		2 How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. Facility has reached out to outside vendor to prepare uneven walkway, awaiting quote. 3 What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur: Maintenance director has completed fully assessment for walkway leading from or to facility. Will complete monthly assessment and report any findings to Administrator 4 How will the facility monitor its performance to make sure that solutions are sustained; the plan is implemented, and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? Maintenance Director will complete monthly assessment and report any findings to Administrator to be corrected. The results of these audits will be reviewed in Quality Assurance	

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(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
			Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 Date of compliance: TBD	
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Based on observation, records review, and interview, the facility failed to ensure 1 of 1 emergency battery backup lights was tested monthly and annually. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect maintenance staff in the main boiler room. Findings include: Based on an observation with the Maintenance	K 0291	**K291** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1 How the corrective action will be accomplished for those residents found to be affected by	10/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 01 B. WING	10/01/2024

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	Director on 10/01/24 at 12:50 p.m., there was a battery-powered emergency light in the main boiler room by the transfer switch. Based on records review at 2:30 p.m., no documentation available to show a 90-minute annual test or a 30-second monthly test was conducted for the light in the last 12 months. Based on an interview at the time of record review, the Maintenance Director stated it is unknown if the light was tested monthly and annually and the light did look like a battery powered light but did not know for sure. The findings were reviewed with the Director of Nursing, Assistant Director of Nursing, and the Maintenance Director at the exit conference. 3.1-19(b)		the deficient practice: No residents were negatively affected. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. No additional emergency lighting test need during facility wide audit. 3 What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur: Maintenance director and/or designee will conduct a 90-minute test for annual testing and moving forward will do 30 second test monthly testing for powered emergency lighting for 12 months. 4 How will the facility monitor its performance to make sure that solutions are sustained; the plan is implemented, and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? Maintenance Director will complete annual and/or monthly battery powered emergency lighting for 12 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 01 B. WING	10/01/2024

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			The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 Date of compliance 10/20/24	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 2 of 6 storerooms greater than 50 square feet and being used for storage of large amounts of combustibles were protected as a hazardous area. This deficient practice could affect 30 residents in two smoke compartments. Findings include: Based on observations with the Maintenance Director and Administrator on 03/27/24 at 11:55 a.m., the front storeroom and the side storeroom contained over 20 boxes of supplies, was greater than 50 square feet, therefore making the rooms a hazardous area. The side storeroom was not protected as a hazardous area because the corridor door to the room was not self-closing or automatic closing, and the front storeroom did not automatically latch into the frame when tested.	K 0321	K321 This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. How the corrective action will be	10/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 01 B. WING	10/01/2024

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	Based on interviews at the time of observations, the Maintenance Director agreed the two storerooms contained large amounts of combustible storage, was larger than 50 square feet, and the corridor door to the rooms were not self-closing or did not latch. The findings were reviewed with the Director of Nursing, Assistant Director of Nursing, and the Maintenance Director at the exit conference. 3.1-19(b)		accomplished for those residents found to be affected by the deficient practice: • No residents negatively affected. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice: • All residents have the potential to be affected. Storeroom contained over 20 boxes of supplies, was greater than 50sq feet. 3. What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur: • Maintenance director and/or designee has rearrange storeroom making sure all boxes are stored properly and below 50sq feet. And add self-closer to storeroom door. 4. How will the facility monitor its performance to make sure that solutions are sustained; the plan is implemented, and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? • Maintenance director will conduct monthly audits in storeroom making sure boxes and supplies are store correctly and less than 50sq feet. Administrator	

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	155064	A. BUILDING 01 B. WING	10/01/2024

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			will review audit during monthly safety committee meeting. The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Date of compliance 10/20/24	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities (#1.) 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) 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	K 0324	**K324** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of*	10/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 01 B. WING	10/01/2024

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	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. This deficient practice could affect five residents in the therapy gym. (#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 30 residents in the main dining room. The findings include: Based on observation with the Maintenance Director on 10/01/21 between 11:30 a.m. and 2:00 p.m.: (#1) There was a cooktop in the therapy gym that was separated from the corridor, but staff were		*federal and state law.* 1 How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No residents negatively affected. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. Facility has reached out to outside vendor to add shutoff so that staff can have access. Schedule date for vendor to come is 10/18/2024. 3 What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur: Facility has reached out to outside vendor to come install shutoff. Maintenance and/or designee will conduct monthly audit once shut off is installed to make sure working properly. 4 How will the facility monitor its performance to make sure that solutions are sustained; the plan is implemented, and the corrective action evaluated for its	

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	155064	A. BUILDING 01 B. WING	10/01/2024

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	unable to deactivate the cooktop from power. Based on interview at the time of observation, the Maintenance Director was asked if staff were able to deactivate the cooktop and lock the switch. The Maintenance director stated a shut off switch was not found. (2.) 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 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. The findings were reviewed with the Director of Nursing, Assistant Director of Nursing, and the Maintenance Director at the exit conference. 3.1-19(b)		effectiveness; and the plan of correction is integrated into the quality assurance system? Maintenance director will conduct monthly audits monthly audit once shut off is installed to make sure working properly. The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 Date of compliance 10/18/24	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing (#1.) Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2	K 0353	**K353** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement*	10/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 01 B. WING	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. (#2.) Based on observation and interview, the facility failed to ensure 2 of 2 sprinklers in the kitchen washroom 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. This deficient practice could affect all occupants. Findings include: (#1.) Based on records review with the Maintenance Director on 10/01/24 at 10:13 a.m., there was no monthly inspection of the wet pipe sprinkler system's gauges and valves for the months of October 2023 to April of 2024. During an interview at the time of record review, the Maintenance Director stated the inspection of gauges and valves were not conducted due to there being no Maintenance Director during the aforementioned months.		*by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1 How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No residents were negatively affected. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. Both deficient sprinkler head were replaced on 10/10/2024. Facility wide audit conduct no additional sprinklers with corrosion identified. 3 What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur: Maintenance Director will inspect all sprinkler heads monthly and ensure they are free from corrosion.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 01 B. WING	10/01/2024

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	(#2) Based on observation with the Maintenance Director on 10/01/24 at 1:21 p.m., the two-sprinkler heads in the kitchen washroom were green and showed signs of corrosion. Based on an interview at the time of observation, the Maintenance Director agreed two sprinkler heads in the kitchen washroom showed signs of corrosion. The findings were reviewed with the Director of Nursing, Assistant Director of Nursing, and the Maintenance Director at the exit conference. 3.1-19(b)		4 How will the facility monitor its performance to make sure that solutions are sustained; the plan is implemented, and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? Maintenance Director will conduct monthly checks on all sprinkler heads in the facility to ensure all heads are free from corrosion. The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 Date of compliance 10/10/24	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure the penetrations caused by the	K 0372	**K372**	10/24/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 01 B. WING	10/01/2024

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	passage of wire and/or conduit through 4 of 10 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, 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 smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 40 residents in four smoke compartments. Findings include: Based on observations with the Maintenance Director on 10/01/24 between 1:45 p.m. and 2:15 p.m., the following unsealed penetrations were discovered: a) Above the drop ceiling of smoke wall #1 had a 3/4-inch unsealed gap around wires and black and gray caulk with unknown UL Listing. b) Above the drop ceiling of smoke wall #7 had a 3/4-inch unsealed gap around wires and black and gray caulk with unknown UL Listing. c) Above the drop ceiling of smoke wall #8 had unsealed broken pipe sleeve containing wires. d) Above the drop ceiling of smoke wall #10 had a 3/4-inch unsealed gap around wires and black and gray caulk with unknown UL Listing. e)) Above the drop ceiling of smoke wall #11 had a 3/4-inch unsealed gap around wires and black and gray caulk with unknown UL Listing. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned smoke walls contained unsealed penetrations or gray caulk with unknown UL Listing.		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1 How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No residents negatively affected. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. Maintenance director or designee will update smoke barrier layout to include what doors are safe smoke barriers, plan will include which resident are near non smoke barriers. 3 What measures will be put into place or what systemic changes the facility will make to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 01 B. WING	10/01/2024

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	The findings were reviewed with the Director of Nursing, Assistant Director of Nursing, and the Maintenance Director at the exit conference. 3.1-19(b)		ensure the deficient practice does not recur: Maintenance will complete annual inspections of all smoke barriers to ensure all penetrations are fire caulked. No additional area 4 How will the facility monitor its performance to make sure that solutions are sustained; the plan is implemented, and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? Annual smoke barrier wall checks will be added to Tels Monitoring company. The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 Date of compliance 10/24/24	
K 0511 SS=E	NFPA 101 Utilities - Gas and Electric			

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	155064	A. BUILDING 01 B. WING	10/01/2024

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Bldg. 01	Based on observation and interview, the facility failed to ensure 2 of 2 electrical terminals and 4 of 4 main power switches were maintained in safe operating condition. LSC 19.5.1.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect staff and residents. This deficient practice could affect all residents Findings include: Based on observation with the Maintenance Director on 10/01/24 at 1:11 p.m., in the ADON office there was a light fixture missing two bulbs exposing the copper terminals. Based on an interview at the time of the observation, the Maintenance Director agreed the light was missing two light bulbs in the ADON office with exposed copper terminals. The findings were reviewed with the Director of Nursing, Assistant Director of Nursing, and the Maintenance Director at the exit conference. 3.1-19(b)	K 0511	**K511** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1 How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No residents were negatively affected. The two bulbs missing from the light fixture exposing the copper terminals was fixed. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. Maintenance Director/designee will make checks to ensure that there are no bulbs missing from	10/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 01 B. WING	10/01/2024

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			light fixtures. 3 What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur: Maintenance Director/designee will make checks to ensure that there are no bulbs missing from light fixtures. Checks will be added to quarterly maintenance logs. 4 How will the facility monitor its performance to make sure that solutions are sustained; the plan is implemented, and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? Maintenance Director will bring results to QAA monthly for 6 months and quarterly thereafter if 100% compliant. The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and	

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	155064	A. BUILDING 01 B. WING	10/01/2024

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			make recommendations to revise the plan of correction as indicated. 5 Date of compliance 10/20/24	
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Based on record review, observation, and interview; the facility failed to provide 1 of 1 written Fire Safety Plans (FSP) or know the location of the FSP according to LSC 19.7. (#1.) LSC 19.7.1.1 states that the administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. (#2.) LSC 19.7. states the fire safety plan must incorporat all items listed in NFPA 101, Section 19.7.2.2. 1. Use of alarms. 2. Transmission of alarms to fire department. 3. Emergency phone call to fire department 4. Response to alarms. 5. Isolation of fire. 6. Evacuation of immediate area. 7. Evacuation of smoke compartment. 8. Preparation of floors and building for evacuation. 9. Extinguishment of fire. This deficient practice affects all residents, staff, and visitors in the event of a fire emergency. Findings include:	K 0711	**K711** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1 How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No residents were negatively affected. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice:	10/18/2024

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	(#1.) Based on observations with the Director of Nursing (DON) on 10/01/24 at 12:00 p.m., Management (including the DON and Maintenance Director) did not know the location of the FSP and could not be found in the facility including at the nurse's station, Administrator's office, Maintenance office, nor in the Emergency Preparedness Plan. Based on records review at 3:30 p.m., the DON found a copy of the FSP on the company's web site, but the FSP was a generic plan for the company and did not include specific information for the facility. Based on interviews at 12:10 p.m., the DON was asked where the location of the FSP was located, and the DON stated I am not sure it could be at the nurse's station. When the DON checked the nurse's station the FSP was not located. The FPS was not located until 3:00 p.m. The Maintenance Director also stated he did not know the location of the FSP. (#2.) Based on records review with the Maintenance Director and the DON on 10/01/24 at 3:30 p.m. The provided facility's FSP did not address the following items: a) Evacuation of smoke compartments. The facility did not address the location of the facility's smoke/fire barriers or location of non-barrier cross corridor door that could be mistaken as a smoke/fire barrier. b) Preparation of floors and buildings for evacuation. The facility did not address removing wheeled patient equipment from the corridors and evacuation routes during a fire evacuation. Based on an interview during records review, the DON and the Maintenance Director agreed the FSP did not address the location of the smoke/fire barriers nor clearing the halls of wheeled equipment during a fire evacuation.		All residents have the potential to be affected. Fire Safety Plan updated. Fire safety plan will be placed EOP binders. 3 What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur: Maintenance Director will do monthly audit of EOP binder making sure most updated facility fsp is in binder. 4 How will the facility monitor its performance to make sure that solutions are sustained; the plan is implemented, and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? Maintenance Director/designee Continued review fire safety policies and procedures by Administrator and designee during monthly Performance Improvement meeting. The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an	

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	The findings were reviewed with the DON, Assistant Director of Nursing, and the Maintenance Director at the exit conference. 3.1-19(b)		average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 Date of compliance 10/18/24	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct fire drills on each shift for 3 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 10/01/24 at 10:02 a.m., the following shifts were missing documentation of completed fire drills: a) A third shift fire drill in the first quarter of 2024. b) A third shift fire drill in the second quarter of 2024. c) A first, second, and third shift fire drills in the fourth quarter of 2023. Based on an interview at the time of record review, the Maintenance Director agreed there were five drills that were not completed within the last four	K 0712	**K712** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1 How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No residents were	10/20/2024

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	quarters. This finding was reviewed with the Director of Nursing, Assistant Director of Nursing and the Maintenance Director at the exit conference. 3.1-19(b) 3.1-51(c)		negatively affected. Missing documentation for fire drills 2 How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. Maintenance director will conduct quarterly drills for each shift. All fire drilling up to date 3 What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur: Maintenance Director all shift drill has been conducted and the facility is on track for each shift to practice a fire drill quarterly moving forward for compliance. 4 How will the facility monitor its performance to make sure that solutions are sustained; the plan is implemented, and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? Maintenance Director/designee will provide calendar year form during Safety Committee monthly meeting to	

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			ensure future compliance with rotating shifts. Administrator will review drill audit books. The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 Date of compliance 10/20/24	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on observation and interview, the facility failed to ensure 1 of 2 smoking areas were maintained by disposing of cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect staff and 25 residents using the southeast exit. Findings include: Based on records review with the Maintenance Director on 10/01/24 at 08:35 a.m. and again at 12:40 p.m. outside the southeast exit in the staff smoking area there were over 30 cigarette butts	K 0741	**K741** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is*	10/14/2024

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	disposed on the ground around the exit and smoking area. Also, the provided metal container with a self-closing lid contained both trash and cigarette butts. Based on an interview at the time of observations, the Maintenance Director agreed there were cigarette butts on the ground in the staff smoking area and the metal butt can contained both trash and cigarette butts. This finding was reviewed with the Director of Nursing, Assistant Director of Nursing and the Maintenance Director at the exit conference. 3.1-19(b)		*required by the provisions of federal and state law.* 1 How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No residents were negatively affected. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. No additional cigarette butt identified in facility wide audit. 3 What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur: Maintenance Director removed Cigarette butts off ground outside in the staff smoking area on 10/01/2024. Staff educated on using metal container with self-closing lid. In additional to routine outside facility cleaning. Maintenance director or designee will check all smoking area 4x weekly for 1 month, then 3 x weekly for a monthly, then 2x weekly moving forward.	

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			4 How will the facility monitor its performance to make sure that solutions are sustained; the plan is implemented, and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? Maintenance Director or designee will check all smoking area 4x weekly for 1 month, then 3 x weekly for a monthly, then 2x weekly moving forward. Will bring audit to safety committee meeting monthly for review. The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 Date of compliance 10/14/24	
K 0761 SS=E	NFPA 101 Maintenance, Inspection & Testing - Doors			

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Bldg. 01	Based on observation, records review, and interview: (#1.) The facility failed to ensure 11 of 11 smoke barrier doors are routinely inspected and repaired as part of the facility maintenance program. (#2.) The facility failed to ensure annual inspection and testing of 1 of 1 oxygen room fire doors were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned,	K 0761	**F761** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1 How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No residents negatively affected. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice: All resident has the potential to be affected. Smoke door inspection was scheduled. 3 What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur:	10/14/2024

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	and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice affects all residents. Findings include: (#1.) Based on records review with the Maintenance Director on 10/01/24 at 11:20 a.m., there was no documentation for review to show if the facility's smoke doors were routinely inspected. Based on observation between 11:30 a.m. to 2:00 p.m., there were 11 smoke doors in the facility. Based on interview at the time of observation, the Maintenance Director stated there were eight smoke doors in the facility and did not have documentation of routinely inspected smoke doors. (#2.) Based on records review with the Maintenance Director on 10/01/24 at 10:50 a.m., there was no inspection of the oxygen trans-filling		Maintenance added all 11 smoke doors for annual inspection. Will be monitored monthly by ED/designee for compliance. 4 How will the facility monitor its performance to make sure that solutions are sustained; the plan is implemented, and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? Inspection audits will be review annually by qapi to ensure to in-service as a recurring annual task. The Administrator will review this annually. The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 Date of compliance 10/14/24	

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	155064	A. BUILDING 01 B. WING	10/01/2024

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	room fire door available for review. Based on observation during the tour at 12:50 p.m. there was a one-and-a-half-hour fire door to the oxygen trans-filling room. Based on interviews at the time of records review and observation, the Maintenance Director stated the oxygen trans-filling door is a rated fire door and was not inspected within the last year. The findings were reviewed with the Director of Nursing, Assistant Director of Nursing, and the Maintenance Director at the exit conference. 3.1-19(b)			
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Based on observation, record review and interview, the facility failed to ensure non-hospital grade electrical receptacles at 45 of 45 resident sleeping rooms were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents.	K 0914	**K914** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1 How the corrective action will be accomplished for those residents found to be affected by the deficient practice:	10/24/2024

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	Findings include: Based on observations with the Maintenance Director on 10/01/24 between 12:30 p.m. and 2:00 p.m., the facility's 45 resident sleeping rooms contained four to eight non-hospital-grade electrical receptacles. Based on records review at 11:30 a.m., no documentation was available to show the last time the electrical receptacles in resident sleeping rooms were tested. Based on interview at the time of the observation and records review, the Maintenance Director confirmed all the electrical receptacles in the resident sleeping rooms were not hospital-grade and stated it is unknown the last time the annual testing was completed. The findings were reviewed with the Director of Nursing, Assistant Director of Nursing, and the Maintenance Director at the exit conference. 3.1-19(b)		No residents were negatively affected. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. 3 What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur: Maintenance Director scheduled for outside electrical company come do testing to put facility in compliance on 10/24/2024 and will schedule yearly testing. 4 How will the facility monitor its performance to make sure that solutions are sustained; the plan is implemented, and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? Maintenance Director will monitor and keep track on when annual testing is needed and schedule for outside vendor to come in. Will bring to safety committee meeting and qapi quarterly.	

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			The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 Date of compliance 10/24/24	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interviews, the facility failed to ensure 1 of 1 emergency generators had a reliable source of fuel and conducted required generator testing in accordance with the requirements of NFPA 101-2012 edition section 19.5. NFPA 99-2012 edition, and NFPA 110-2010 Edition. (#1.) NFPA 99 section 6.4.4.1.1.4(a) requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Section 8.4.1 requires an Emergency Power Supply System (EPSS) including all	K 0918	**K918** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	10/20/2024

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(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
	appurtenant components, shall be inspected weekly and exercised monthly. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. (#2.) NFPA 110 section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS): (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 affects all staff, visitors, and residents. Findings include: Based on records review with the Maintenance Director on 10/02/24 at 11:55 a.m.: (#1.) No documentation was available to show the generator set in service was inspected weekly and exercised once monthly under load for a minimum of 30 minutes between the months of October		1 How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No residents were negatively affected. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. No additional required testing identified. 3 What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur: Maintenance Director and/or designee will conduct weekly inspection and exercise once monthly under load for minimum of 30 minutes. Natural gas letter will be placed in EOP binder. 4 How will the facility monitor its performance to make sure that solutions are sustained; the plan is implemented, and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 01 B. WING	10/01/2024

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	2023 to April 2024. (#2.) No letter of reliability for the facility's natural gas generator was provided for review. Based on interviews during records review, the Maintenance Director stated the missing load tests and weekly tests were not conducted due to no Maintenance Director during that time and the natural gas reliability letter could not be found. This finding was reviewed with the Director of Nursing, Assistant Director of Nursing and the Maintenance Director at the exit conference. 3.1-19(b)		Maintenance Director will monitor and keep track on when weekly inspections and monthly under load for minimum of 30 minutes. Will bring to safety committee meeting and qapi quarterly for review. The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 Date of compliance 10/20/24	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 5 residents outside of the housekeeping office.	K 0920	**K920** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the*	10/04/2024

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	Findings include: Based on observations with the Maintenance Director on 10/01/24 at 2:05 p.m., a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in the housekeeping office. Based on an interview at the time of observation, the Maintenance Director agreed a power strip was supplying power to high power draw equipment. The findings were reviewed with the Director of Nursing, Assistant Director of Nursing, and the Maintenance Director at the exit conference. 3.1-19(b)		*facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1 How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No residents were negatively affected. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. No additional power cord identify during facility wide audit. 3 What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur: Maintenance Director and/or designees has educated staff on no use of power strips in facility. Maintenance Director and/or designee will do monthly audit on power strips to ensure not being used in facility.	

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			4 How will the facility monitor its performance to make sure that solutions are sustained; the plan is implemented, and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? Maintenance Director will monitor and keep track of audits on power strips to ensure not being used in facility. Will bring to safety committee meeting and qapi quarterly. The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 Date of compliance 10/04/24	