STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155029	A. BUILDING -- B. WING	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY NURSING AND REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/20/25 Facility Number: 000012 Provider Number: 155029 AIM Number: 100274900 At this Emergency Preparedness survey, Community Nursing and Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 115 certified beds. At the time of the survey, the census was 55. Quality Review completed on 05/28/25	E 0000	**The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. The Facility formally requests a desk review of the following plans of correction.**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/20/25 Facility Number: 000012 Provider Number: 155029 AIM Number: 100274900 At this Life Safety Code survey, Community	K 0000	**The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. The Facility formally requests a desk review of the following plans of correction.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility was determined to be of Type II (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in resident sleeping rooms 133 through 141 and 233 through 237. The facility has smoke detectors hard wired to the fire alarm system installed in all other resident sleeping rooms. The facility has a capacity of 115 and had a census of 55 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for two detached buildings providing facility storage services which are each not sprinklered. Quality Review completed on 05/28/25			
K 0211 SS=F Bldg. 01	NFPA 101 Means of Egress - General Based on observation and interview, the facility failed to ensure all means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect all residents, staff and visitors if needing to exit the facility. Findings include:	K 0211	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Items stored outside of Room 232 corridor were removed. cart outside Room 139 and 212 was replaced with wheeled . chair was removed outside of Room 141 in	06/20/2025

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	Based on observations on 05/20/25 with the Maintenance Director, the following was noted: a. at 12:29 p.m., three mattress and old wheeled type buffet food cart were stored in the corridor outside resident sleeping Room 232 on the second floor. The items projected over two feet into the eight foot wide corridor. b. at 12:39 p.m., a plastic three drawer chest of drawers for isolation supplies was stored in the corridor outside resident sleeping Room 212 on the second floor. The chest of drawers was not wheeled and projected one foot into the eight foot wide corridor. c. at 1:43 p.m., a wooden three drawer chest of drawers and a plastic three drawer chest of drawers for isolation supplies was stored in the corridor outside resident sleeping Room 139 on the first floor which projected 20 inches into the eight foot wide corridor. Neither item was wheeled or affixed to the floor or to the wall. d. at 1:44 p.m., a wooden chair was placed directly in front of the north exit door to the outside of the facility on the first floor by resident sleeping Room 141 on the first floor. e. at 1:51 p.m., a chair was stored in the corridor outside resident sleeping Room 124 on the first floor which projected twenty inches into the eight foot wide corridor. The chair was not affixed to the floor or to the wall. Based on interview at the time of each of the observations, the Maintenance Director agreed the aforementioned means of egress on each floor was not continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference.		front of exit door. outside of Room 124 corridor was removed. **How be and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. The maintenance director or will conduct rounds to ensure that corridors are free from items. Any issues will be immediately rectified. **What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur?** Maintenance director or designee will do a weekly walk through to ensure compliance. Executive director to compliance. **How be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?** Maintenance director or designee will do a weekly walk through for six months to ensure compliance with results brought to QAPI for review. If a threshold of 100% is not met, an action plan will be developed to ensure compliance. Executive director to compliance.	

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K 0222 SS=E Bldg. 01	3.1-19(b) NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through 1 of 3 stairwell exits on the second floor 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 Section 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 10 residents, staff and visitors if needing to exit the facility from the second floor. Findings include: Based on observations with the Maintenance Director at 12:36 p.m. on 05/20/25, the stairwell exit door by resident sleeping Room 232 on the second floor was marked as a facility exit with an exit sign. The door could be opened by entering a four digit code at a keypad by the exit door but the correct code to open the door was not posted. The Maintenance Director stated the posted code was incorrect and tried several times to either enter the correct code or reset the keypad with a new code. The Maintenance Director was able to reset the keypad with a new code and the door was able to release to open after the code was reset. Based on interview at 12:36 p.m. on 05/20/25, the Maintenance Director agreed the incorrect code had been posted at the stairwell exit door.	K 0222	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility will post codes to exit doors in an obvious fashion at the exit door located on the second floor. **How be and what corrective action will be taken?** All residents with access to exit doors have the potential to be affected by the deficient practice. The code is now posted at the exit door in an obvious fashion. The maintenance director or will conduct rounds to ensure that codes are posted. Any issues will be immediately rectified. **What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur?** Maintenance director or designee will do an audit of the facility monthly to ensure that codes are posted in an obvious fashion. Any issues will be immediately rectified. director or will do a monthly walk through to ensure compliance. Executive director to compliance. **How be monitored to ensure the deficient practice will not recur and what quality**	06/20/2025

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	These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		**assurance program will be put into place?** Maintenance director or designee will do a monthly walk through for six months to ensure compliance with results brought to QAPI for review. If a threshold of 100% is not met, an action plan will be developed to ensure compliance. Executive director to compliance.	
K 0225 SS=E Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Based on observation and interview, the facility failed to ensure items stored in 1 of 3 interior fire escape stairways would not interfere with egress. LSC 7.2.2.5.3.1 states open space within the exit enclosure shall not be used for any purpose that has the potential to interfere with egress. This deficient practice could affect 10 residents, staff and visitors using the exit stairwell on the first floor by the elevator. Findings include: Based on observations with the Maintenance Director at 1:36 p.m. on 05/20/25, the exit stairwell on the first floor by the elevator was marked as a facility exit with an exit sign. Two shelves, a broom, a dust pan, an extension cord and an electrical tool were stored in the stairwell on the first floor which would interfere with egress. Based on interview at 1:36 p.m. on 05/20/25, the Maintenance Director agreed the aforementioned stairwell on the first floor was used for storage which could interfere with egress and removed the items from the stairwell. These findings were reviewed with the Executive	K 0225	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Items in the exit stairwell on the first floor by the elevator were removed. **How be and what corrective action will be taken?** All residents have the potential to be affected by this deficient practice. The maintenance director or will conduct weekly rounds to ensure that corridors are free from items. Any issues will be immediately rectified. **What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur?** Maintenance director or designee a weekly walk through to ensure compliance. Executive director to compliance. **How be monitored to ensure the deficient practice will not recur and what quality**	06/20/2025

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	Director and the Maintenance Director during the exit conference. 3.1-19(b)		**assurance program will be put into place?** Maintenance director or designee will do a monthly walk through for six months to ensure compliance with results brought to QAPI for review. If a threshold of 100% is not met, an action plan will be developed to ensure compliance. Executive director to compliance.	
K 0291 SS=D Bldg. 01	NFPA 101 Emergency Lighting Based on record review, observation and interview; the facility failed to document monthly testing for 1 of 4 battery backup lights in the facility in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) 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, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (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 over one staff and visitors in the HR Office.	K 0291	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? HR location emergency light fixture has been removed as it is not required. **How be and what corrective action will be taken?** No residents have the potential to be affected by deficient practice. **What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur?** The maintenance director or designee will remove emergency light . Executive director to compliance. **How be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?** Maintenance director or designee will do a monthly walk through for six months to ensure	06/20/2025

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	Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency and Exit Lighting: Conduct a 90-minute operational test" documentation dated 04/09/25 with the Maintenance Director at 10:55 a.m. on 05/20/25, a total of four battery backup lights were annually functional tested for 90-minutes on 04/09/25. The 04/09/25 annual functional testing documentation included an "HR" location. Review of Direct Supply TELS Logbook Documentation "Emergency and Exit Lighting: Conduct a 30-second functional test" documentation for the most recent twelve month period only listed a total of three battery backup lights were located in the facility. The battery backup light locations did not include the "HR" location. Based on interview at 10:55 a.m. on 05/20/25, the Maintenance Director stated he recently found out about the HR light location, it needs to be added to the monthly TELS testing documentation and agreed additional monthly HR light testing documentation for the most recent twelve month period was not available for review. Based on observations with the Maintenance Director at 1:10 p.m. on 05/20/25, one battery backup light was located in the Human Resources Office (the HR location) near the service corridor which illuminated when its respective test button was pushed. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		compliance with results brought to QAPI for review. If a threshold of 100% is not met, an action plan will be developed to ensure compliance. Executive director to compliance.	

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K 0300 SS=C Bldg. 01	NFPA 101 Protection - Other Based on record review, observation and interview; the facility failed to ensure preventative maintenance for all battery operated smoke alarms in resident rooms was performed. 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. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Detectors Test: battery operated smoke detectors" documentation for the most recent twelve month period with the Maintenance Director at 11:30 a.m. on 05/20/25, battery operated smoke detector cleaning documentation was not available for review. Based on interview at 11:30 a.m. on 05/20/25, the Maintenance Director stated the facility tests the battery operated smoke detectors in select resident sleeping rooms on a weekly basis, cleaning documentation might be in TELS but agreed cleaning documentation was not available for review at the time of the survey. At 12:29 p.m. on 05/20/25, during a tour of the facility, manufacturer's documentation affixed to the smoke detector installed in resident sleeping Room 257 stated test the detector weekly and to clean the detector monthly. Based on interview at 12:29 p.m. on 05/20/25, the Maintenance Director stated the same type of battery operated smoke detector is installed in each resident sleeping room which does not have a fire alarm system smoke detector installed in the room. These findings were reviewed with the Executive Director and the Maintenance Director during the	K 0300	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Cleaning of all battery-operated smoke detectors, including room 257 completed and documentation placed in TELS Logbook documentation. **How be and what corrective action will be taken?** All residents have the potential to be affected by this deficient practice. Maintenance director or will complete weekly testing and monthly cleaning battery operated smoke detectors. Maintenance Director completed cleaning of all smoke detectors. **What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur?** Maintenance director or designee will add testing schedule and a monthly cleaning schedule to system. will monitor compliance. **How be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?** Maintenance director or designee will do a weekly testing and monthly cleaning QAPI for six months to ensure compliance with results brought to	06/20/2025

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	exit conference. 3.1-19(b)		QAPI for review. If a threshold of 100% is not met, an action plan will be developed to ensure compliance. Executive director to compliance.	
K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings - Enclosure Based on observation and interview, the facility failed to maintain protection of 1 of 3 interior stairwells. LSC 19.3.1 requires vertical openings shall be enclosed or protected in accordance with Section 8.6. LSC 8.6.1 requires every floor that separates stories in a building shall be constructed as a smoke barrier. LSC 8.6.5 states see 7.1.3.2.1 for enclosures of exits. LSC 7.1.3.2.1 states the separation shall have a minimum 1-hr fire resistance rating where the exit connects three stories or less. This deficient practice could affect over 10 residents, staff and visitors on the second floor. Findings include: Based on observations with the Maintenance Director at 12:15 p.m. on 05/20/25, the latching mechanism on the stairwell door by the elevator on the second floor would not protrude into the door frame which caused the stairwell door to not latch into the door frame when tested to close multiple times. The stairwell door was equipped with a 90-minute fire resistance rating label affixed to the hinge side of the door. Based on interview at 12:15 p.m. on 05/20/25, the Maintenance Director agreed the stairwell door not latch into the door frame and did not maintain the fire resistance rating of the stairwell vertical opening. These findings were reviewed with the Executive	K 0311	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The latching mechanism on the stairwell door by the elevator on the second floor was fixed to the latch. **How be and what corrective action will be taken?** All residents have the potential to be affected by this deficient practice. director or will complete weekly rounds to ensure latches on door work properly. will monitor compliance. **What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur?** Maintenance director or designee will complete weekly rounds to ensure latches on door work properly. will monitor compliance. **How be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?** Maintenance director or designee will do a weekly walk through for door latches on door for six months to ensure	06/20/2025

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	Director and the Maintenance Director during the exit conference. 3.1-19(b)		compliance with results brought to QAPI for review. If a threshold of 100% is not met, an action plan will be developed to ensure compliance. Executive director to compliance.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 1 second floor Activities Offices in accordance with LSC 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in Section 8.5.5.2 and Section 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect over ten residents, staff and visitors in the vicinity of the Activities Office on the second floor. Findings include: Based on observations with the Maintenance Director at 12:44 p.m. on 05/20/25, a curtain with no mesh was hung in place across the closet area of the second floor Activities Office which blocked the sprinkler spray pattern of the sprinkler in the closet. The closet did not have a door. The curtain was in place to cover the closet area. The top of the curtain was installed within six inches of the ceiling. Based on interview at 12:44 p.m.,	K 0351	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Director removed curtain blocking sprinkler coverage. **How be and what corrective action will be taken?** All residents have the potential to be affected by this deficient practice. Maintenance director or removed curtains and staff educated. **What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur?** Maintenance director or designee will complete monthly rounds to ensure sprinkler systems are not blocked. will monitor compliance. **How be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?** Maintenance director or designee will do a monthly through to ensure sprinklers are not blocked for six months to ensure compliance with results brought to QAPI for review. If a threshold of	06/20/2025

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	the Maintenance Director agreed the curtain would obstruct the sprinkler coverage in the room and removed the curtain. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		100% is not met, an action plan will be developed to ensure compliance. Executive director to compliance.	
K 0353 SS=D Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler heads in 1 of the 2 visitor's restrooms behind the reception desk in the first floor lobby which was rusted was replaced in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states 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. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler.	K 0353	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Maintenance director or contacted IEI regarding replacement. **How be and what corrective action will be taken?** All residents have the potential to be affected by this deficient practice. director or contacted IEI for replacement. All sprinkler heads were checked to ensure the integrity of the sprinkler head by the maintenance director**What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur?** Maintenance director or designee will complete monthly rounds to ensure sprinkler heads are free of rust. will monitor compliance. **How be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?** Maintenance director	06/20/2025

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	This deficient practice could affect over five residents in the vicinity of the first floor main entrance lobby. Findings include: Based on observations with the Maintenance Director at 1:02 p.m. on 05/20/25, the ceiling mounted sprinkler located in the visitor's restroom directly behind the reception desk in the main entrance lobby on the first floor was covered with rust. Based on interview at 1:02 p.m. on 05/20/25, the Maintenance Director agreed the aforementioned sprinkler location was loaded with rust. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		or designee will do a monthly through to ensure sprinkler heads are free of rust for six months to ensure compliance with results brought to QAPI for review. If a threshold of 100% is not met, an action plan will be developed to ensure compliance. Executive director to compliance.	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Based on observation and interview, the facility failed to ensure 1 of 1 therapy rooms were separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct	K 0361	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Maintenance director or will contact to replace lock **How be and what corrective action will be taken?** All residents have the potential to be affected by this deficiency practice. Maintenance director or will contact ADA . **What measures will be put into place and what systemic changes will be made to ensure the deficient practice**	06/20/2025

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	access to required exits. This deficient practice could affect over five residents, staff and visitors in the vicinity of the Therapy Room on the first floor. Findings include: Based on observations with the Maintenance Director at 12:50 p.m. on 05/20/25, the corridor door to the Therapy Room near the main entrance lobby on the first floor was not equipped with a positive latching mechanism to latch the door into the door frame. The door was equipped with a thumb twist locking device which required a key to lock or unlock the door from the corridor side of the door. The door would not latch into the door frame unless it was locked. Based on interview at 12:50 p.m. on 05/20/25, the Maintenance Director agreed the corridor door to the Therapy Room was not equipped with a positive latching device to secure the door into the door frame and to ensure the treatment room was not open to the corridor. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		**does not recur?** Maintenance director will complete a 1x audit to ensure all locks are within code. **How be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?** Maintenance director or designee will do a monthly through to ensure locks within the facility are within code for six months to ensure compliance with results brought to QAPI for review. If a threshold of 100% is not met, an action plan will be developed to ensure compliance. Executive director to compliance.	
K 0362 SS=E Bldg. 01	NFPA 101 Corridors - Construction of Walls Based on observation and interview, the facility failed to ensure corridor walls in 1 of 7 smoke compartments on the first floor were constructed to resist the transfer of smoke. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of mechanical room by resident sleeping Room 131 on the first floor.	K 0362	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The HVAC unit was repaired to ensure it was flush with the grill opening in the door **How be and**	06/20/2025

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	Findings include: Based on observations with the Maintenance Director at 1:42 p.m. on 05/20/25, a 16 inch by 16 inch grill was installed in the bottom of the corridor door to the mechanical room by resident sleeping Room 131 on the first floor. The grill was meant to be a return for HVAC equipment in the mechanical room but the return was not flush with the grill and would not resist the transfer of smoke. Based on interview at 1:42 p.m. on 05/20/25, the Maintenance Director agreed the HVAC return was not flush with the grill opening in the door and would not resist the passage of smoke. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		**what corrective action will be taken?** All residents have the potential to be affected by this deficiency practice. All corridor walls were inspected to ensure walls would resist the transfer of smoke by the maintenance director **What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur?** Corridor walls will be inspected monthly to ensure there is no transfer of smoke by the maintenance director **How be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?** Maintenance director or designee a monthly inspection of corridor to ensure there is no opportunity of transfer of smoke within the facility for six months to ensure compliance with results brought to QAPI for review. If a threshold of 90% is not met, an action plan will be developed to ensure compliance. Executive director to monitor for compliance.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 1 of 4 sets of smoke barrier doors on the first floor would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8	K 0374	What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	06/20/2025

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	requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the smoke barrier door set by resident sleeping Room 115 on the first floor. Findings include: Based on observations with the Maintenance Director at 1:37 p.m. on 05/20/25, the cross corridor door set by resident sleeping Room 115 on the first floor was equipped with a door closing coordinator installed on the door frame but the door set failed to fully self close which left a large gap in between the meeting edges of the door set when tested to close multiple times. The door closing coordinator failed to function properly. Each door in the door set was held in the fully open position with wall mounted magnetic hold open devices set to release with fire alarm system activation and was equipped with self closing devices. Based on interview at 1:37 p.m. on 05/20/25, the Maintenance Director agreed the cross corridor door set by resident sleeping Room 115 on the first floor failed to fully self close because the door closing coordinator failed to function properly. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		Maintenance director or designee adjusted door coordinator Room 115. **How be and what corrective action will be taken?** All residents have the potential to be affected by this deficient practice. director or will complete walk through to ensure coordinator is working properly. All cross coordinator door sets were checked to ensure proper closure by the maintenance director. **What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur?** Maintenance director or designee will complete walk through to ensure coordinator is working properly. **How be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?** Maintenance director or will do a weekly through to ensure door coordinator within the facility within code for six months to ensure compliance with results brought to QAPI for review. If a threshold of 100% is not met, an action plan will be developed to ensure compliance. Executive director to compliance.	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills			

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	Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the third shift for four of four calendar quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of Direct Supply TELs Logbook Documentation "Fire Drills" with the Maintenance Director at 11:30 a.m. on 05/20/25, ten of twelve third shift fire drills were conducted at 6:00 a.m. Documentation for the following ten third shift fire drills conducted within the most recent twelve month period on 05/21/24, 06/21/24, 07/31/24, 09/24/24, 10/28/24, 12/31/24, 01/31/25, 02/27/25, 03/25/25 and on 04/30/25 indicated the fire drill was conducted at 6:00 a.m. In addition, the third shift fire drill on 08/31/24 was conducted at 5:30 a.m. and the third shift fire drill on 11/26/24 was conducted at 6:15 a.m.. Based on interview at 11:30 a.m. on 05/20/25, the Maintenance Director stated the facility operates three shifts per day, additional third shift fire drill documentation within the most recent twelve month period was not available for review and agreed the aforementioned third shift fire drills were not conducted at unexpected times under varying conditions. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Maintenance director will complete a fire drill on 5/30/2025 at 4:00 **How be and what corrective action will be taken?** All residents have the potential to be affected by this deficient practice. Maintenance director or designee will complete schedule in TELS to ensure fire are at unexpected times on third shift. **What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur?** Maintenance director or will complete in TELS. Schedule will be reviewed by ED to ensure fire drills are conducted at different times on third shift **How be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?** Maintenance director or will do a monthly through to ensure fire drills are complete for six months to ensure compliance with results brought to QAPI for review. If a threshold of 100% is not met, an action plan will be developed to ensure compliance. Executive director to compliance.	06/20/2025
K 0761 SS=E	NFPA 101 Maintenance, Inspection & Testing - Doors			

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Bldg. 01	Based on record review, observation and interview; the facility failed to ensure proper operation was maintained for 1 of 1 rolling steel fire doors 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, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition, Section 11.4.1.1 requires an automatic-closing device shall be installed on every rolling steel door. Section 11.4.1.2 states rolling steel doors shall close automatically upon activation or release of a fusible link or detector. Section 11.4.2.2.1 states that after the automatic closing is activated, the door shall remain in the closed position until the automatic-closing device has been reset. This deficient practice could affect over 20 residents, staff and visitors in the dining room on the first floor. Findings include: Based on review of the rolling fire door inspection contractor's "Fire Door Drop Test" documentation dated 09/11/24 with the Maintenance Director at 10:58 a.m. on 05/20/25, the rolling fire door in the kitchen was listed as having "no reported deficiencies". Based on review of the "Remarks" section of Direct Supply TELS Logbook Documentation "Fire Drills" documentation dated 04/30/25, the facility is "waiting on roll down door repairs". Based on interview at 10:58 a.m. on 05/20/25, the Maintenance Director stated the rolling fire door in the kitchen does not operate	K 0761	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Maintenance Director placed order for rolling door on 6/11/2025. Waiver request submitted due to parts for repair/replacement of the rollup door are not in stock and need to be ordered by the vendor. **How be and what corrective action will be taken?** All residents have the potential to be affected by deficient practice. Maintenance Director placed order for rolling door on 6/11/2025.**What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur?** Additional safety measures to compensate for deficiency during waiver period are additional fire drills. Once replaced, Maintenance director or will test rolling door 3x a month to ensure working properly during fire drill on TELS. **How be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?** Maintenance director or designee will do a monthly walk through to ensure rolling door is working properly during fire drills for six months to ensure compliance with results brought to	09/15/2025

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	automatically, an older part needs replacement which may not be available, and they may have to replace the door. The Maintenance Director stated documentation for the status of the repair or replacement was not available for review. Based on observations with the Maintenance Director at 12:59 p.m. on 05/20/25, the metal rolling fire door between the kitchen and main Dining Room on the first floor was equipped with a 90-minute fire resistance rating label affixed to the door. The main Dining Room on the first floor was not open to the corridor. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		QAPI for review. Additional fire drills during waiver period will be brought to QAPI meeting bi-monthly for review. If a threshold of 100% is not met, an action plan will be developed to ensure compliance. Executive director to monitor for compliance	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review, observation and interview; the facility failed to ensure a complete written record of monthly testing of emergency generator starting batteries was maintained for 11 months of the most recent 12 month period in accordance with NFPA 99. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. NFPA 110, Section 8.3.7.1 states the maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted. This deficient practice could affect all residents, staff and visitors.	K 0918	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Maintenance director will perform a conductivity test on the battery to the generator. **How be and what corrective action will be taken?** Maintenance director will perform a conductivity test on the battery to the generator. **What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur?** Maintenance Director will perform a conductivity test monthly and document in . ED will	06/20/2025

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	Findings include: Based on review of the generator inspection contractor's "Inspection Report" documentation dated 12/04/24 with the Maintenance Director at 10:58 a.m. on 05/20/25, the results of emergency generator starting battery electrolyte testing was listed as passing. Review of Direct Supply TELS Logbook Documentation "Emergency Generators: Test generator under load" documentation dated 04/09/25 stated "n/a" in response to "Battery Specific Gravity" and "Battery Conductance Test". Based on interview at 10:58 a.m. on 05/20/25, the Maintenance Director stated additional emergency generator starting battery testing documentation for the most recent twelve month period was not available for review and only the generator contractor performs battery electrolyte testing or conductance testing. Based on observations with the Maintenance Director at 1:15 p.m. on 05/20/25, the facility has one diesel-fuel fired emergency generator located outside the building on the west side of the property. Manufacturer's nameplate documentation affixed to the generator indicated it was rated at 200 kW. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		ensure the monthly conductivity test is completed monthly by reviewing . **How be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?** Maintenance director or designee with conduct a monthly conductivity test for to ensure compliance with results brought to QAPI for review. If a threshold of 100% is not met, an action plan will be developed to ensure compliance. Executive director to monitor for compliance	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on record review, observation and interview; the facility failed to ensure 1 of 1 extension cords were not used as a substitute for fixed wiring in 1 of 1 first floor dining rooms. LSC	K 0920	What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	06/20/2025

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	19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. This deficient practice could affect over 20 residents, staff and visitors in the dining room on the first floor. Findings include: Based on review of the "Fire/Explosion Emergency Action Plan" section of "Emergency Preparedness Program" documentation dated 03/14/25 with the Executive Director and the Maintenance Director at 11:30 a.m. on 05/20/25, "the use of extension cords in lieu of permanent wiring is prohibited" in the facility. Based on observations with the Maintenance Director at 1:05 p.m. on 05/20/25, an orange extension cord was plugged into a wall mounted electrical outlet box above the cabinets above the sink in the dining room on the first floor. The extension cord was run above the suspended ceiling tiles and was connected to a ceiling mounted camera in the corner of the room. Based on interview at 1:05 p.m. on 05/20/25, the Maintenance Director agreed an extension cord was being used as a substitute for fixed wiring in first floor dining room. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		Power cords removed from room. **How be and what corrective action will be taken?** All residents have the potential to be affected by this deficient practice. **What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur?** Maintenance director or will complete monthly work through to ensure power cords are not used outside of code. **How be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?** Maintenance director or a monthly through to ensure power cords are not used outside of . for six months to ensure compliance with results brought to QAPI for review. If a threshold of 100% is not met, an action plan will be developed to ensure compliance. Executive director to monitor for compliance	

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