STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155219	A. BUILDING -- B. WING	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

(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: 10/17/24 Facility Number: 000124 Provider Number: 155219 AIM Number: 100266730 At this Emergency Preparedness survey, Majestic Care of South Bend was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 103 certified beds. At the time of the survey, the census was 68. Quality Review completed on 10/21/24	E 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the low scope and severity of these findings we respectfully request a desk review in lieu of a traditional revisit.	
E 0015 SS=F Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.1 Subsistence Needs for Staff and Patients Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice	E 0015	E0015 – Emergency Preparedness Policy and Procedures It is the practice of this facility to ensure that a thorough Emergency Action Plan (EAP) is up-to-date, and staff are educated in the even that staff and/or residents need to shelter in place or evacuate during an emergency. What corrective action(s) will be accomplished for those residents	11/07/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bud Johnson	Executive Director	11/12/2024

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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	could affect all residents and staff. Findings include: Based on record review and interview with the Maintenance Director from 9:40 a.m. to 12:40 p.m. on 10/17/24, documentation of a three-day emergency food supply and an emergency menu and dietary plan was provided; however, no other policy, plan or procedure was provided regarding water, medical, and pharmaceutical supplies; alternate sources of energy to maintain: temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; emergency lighting; fire detection, extinguishing, and alarm systems; or sewage and waste disposal. Based on interview, the Maintenance Director stated the previous Executive Director had planned to review, revise and update the Emergency Preparedness Plan but it was not completed. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.		found to have been affected by the deficient practice: The facility EAP policies and procedures were developed, updated, and will be maintained by the Maintenance Director/Designee under the guidance of the Executive Director. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by the deficient practice. Full facility updates and development of the EAP policies, procedures, and training will be reviewed by the Maintenance Director/Designee under the guidance of the Executive Director, monthly x 3 months, and bi-annually thereafter. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director, under the supervision of the Executive Director, will review and update EAP policies and procedures, monthly x 3 months, and bi-annually thereafter.	

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool "Emergency Action Plan Preparedness" monthly x 3 months and bi-annually thereafter. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. By what date the systemic changes will be completed: 11/7/2024 Compliance Date: 11/7/2024	
E 0032 SS=F Bldg. --	403.748(c)(3), 416.54(c)(3), 418.113(c)(Primary/Alternate Means for Communication Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (3) Primary and alternate means for communicating with the following: (i) LTC facility's staff (ii) Federal, State, tribal, regional, or local emergency management	E 0032	E0032 – Primary and Alternate Means for Communication It is the practice of this facility to ensure that there are a primary and alternate means of	11/07/2024

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	agencies in accordance with 42 CFR 483.73(c)(3). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director from 9:40 a.m. to 12:40 p.m. on 10/17/24, the Emergency Preparedness Communication Plan provided with a revision date of March 2024, did not address primary and alternate means for communication. Based on interview, the Maintenance Director stated the previous Executive Director had planned to review, revise and update the Emergency Preparedness Plan including the Communications Plan but had not completed it. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.		communication for the facility. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Primary and Alternate means of communication will be developed, updated, and maintained by the Maintenance Director/Designee under the guidance of the Executive Director. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by the deficient practice. Identification and development of the Primary and Alternate means of communication, policies, procedures, and training will be reviewed by the Maintenance Director/Designee under the guidance of the Executive Director, monthly x 3 months, and bi-annually thereafter. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All staff will be in-serviced on or before 11/7/2023. This in-service	

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			will be conducted by the Maintenance Director or Designee and will include a review of egress doors and proper signage. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. By what date the systemic changes will be completed: 11/7/2024	

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			Compliance Date: 11/7/2024	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in	E 0039	E0039- Emergency Plan Testing It is the practice of this facility to ensure all emergency plan exercises are completed twice per year to include unannounced staff drills using the emergency procedures. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Emergency plan exercises will be conducted by the Maintenance Director/Designee under the guidance of the Executive Director. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this deficient practice. The Maintenance Director/Designee under the guidance of the Executive Director will be responsible for completing emergency plan testing for the facility at a minimum bi-annually.	11/07/2024

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	accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director from 9:40 a.m. to 12:40 p.m. on 10/17/24, the facility provided documentation of emergency preparedness training conducted; however, no documentation of exercises was available. Based on record review and interview, the Maintenance Director provided documentation of emergency preparedness training but not of exercises conducted. The Maintenance Director stated that no further documentation of any exercises conducted was available. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.		What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Emergency plan exercises for the facility will be conducted on or before 11/7/2024. These exercises will be conducted by the Maintenance Director or Designee under the guidance of the Executive Director and will include a review of the facility's emergency plan. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for reviewing the facility's emergency action plan monthly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. By what date the systemic	

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			changes will be completed: 11/7/2024 Compliance Date: 11/7/2024	
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: 10/17/24 Facility Number: 000124 Provider Number: 155219 AIM Number: 100266730 At this Life Safety Code survey, Majestic Care of South Bend 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 V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard-wired smoke detectors in the resident rooms. The facility has a capacity of 103 and had a census of 68 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the low scope and severity of these findings we respectfully request a desk review in lieu of a traditional revisit.	

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	Quality Review completed on 10/21/24			
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities 1.) Based on record review and interview; the facility failed to provide documentation of 1 of 1 kitchen exhaust system annual or semiannually cleaning and inspection. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect kitchen staff only.	K 0324	K324 – Cooking Facilities It is the practice of this facility to ensure all equipment is properly installed and maintained. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Maintenance Director has scheduled for SafeCare to adjust the ANSUL “Remote Pull Station” and have it remounted between 42 in. and 48 in. above the floor height. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All staff in kitchen have the potential to be affected by this deficient practice. The Maintenance Director/Designee will be responsible for ensuring that ventilation control and fire protection of commercial cooking operations inspections will be conducted and all operations meet the NFPA 101, Life Safety Code.	11/11/2024

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	Findings include: Based on record review and interview with the Maintenance Director from 9:40 a.m. to 12:40 p.m. on 10/17/24, photographs of the kitchen exhaust system were provided allegedly showing the system had been cleaned and inspected; however, no other documentation was provided to show when the inspection and cleaning had been conducted. Based on interview the Maintenance Director stated he could get a copy of the documentation but failed to provide any documentation at the time of survey. 2.) Based on observation and interview, the facility failed to maintain 1 of 1 kitchen extinguishing system in accordance with NFPA 96, Standard for Ventilation and Fire Protection of Commercial Cooking Operations, Section 10.5.1 states A readily accessible means for manual activation shall be located between 42 in. and 48 in. above the floor, be accessible in the event of a fire, be located in a path of egress, and clearly identify the hazard protected. Additionally, NFPA 101, Life Safety Code, 4.6.12.3 states that existing life safety features obvious to the public, if not required by the code, shall be either maintained or removed. This deficient practice could affect kitchen staff only. Findings include: Based on observation and interview with the Maintenance Director from 12:41 p.m. to 3:00 p.m. on 10/17/24, the ANSUL "Remote Pull Station" was mounted 60.5 inches above the floor next to the cooking area in the kitchen. Based on interview at time of observation, the Maintenance Director stated the measurement as measured with		What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director will be in-serviced on or before 11/2/2024. This in-service will be conducted by the Executive Director and will include a review of NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will bring findings to the Quality Assurance and Performance Improvement Committee for review and follow-up. By what date the systemic changes will be completed: 11/11/2024 Compliance Date: 11/11/2024	

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	a measuring tape. During discussion about the height requirement, the Maintenance Director inquired about being "grandfathered" because the pull station had been in the location since installation. These findings were reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to ensure 1 of 1 backflow prevention device in the sprinkler system piping was tested annually in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 13.6.2.1 states all backflow preventers installed in fire protection system piping shall be tested annually by conducting a forward flow test of the system at the designed flow rate, including hose stream demand, where hydrants or inside hose stations are located downstream of the backflow preventer. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director from 9:40 a.m. to 12:40 p.m. on 10/17/24, there was no documentation of an annual backflow preventer test available for review over the past year on the backflow preventer device for the sprinkler system water supply. Based on interview, the Maintenance	K 0353	K353 – Sprinkler Systems – Maintenance and Testing It is the practice of this facility to maintain sprinkler systems and ensure all automatic sprinkler backflow testing has been inspected and maintained with all supporting documentation. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Maintenance Director had SafeCare conduct back flow prevention test on 8/20/2024 through Work Order 164112. Devices in the sprinkler system were tested annually in accordance with NFPA 25, Standard for the Inspection, testing, and Maintenance of Water-Based Fire Protection	11/07/2024

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	Director stated he could get the documentation but was unable to provide any documentation at the time of survey. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		Systems, 2011 Edition, Section 13.6.2.1. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents and staff have the potential to be affected by this deficient practice. The Maintenance Director/Designee will be responsible for ensuring that sprinkler system backflow prevention devices are inspected at a minimum annually, with all supporting documentation filed in the life safety binder for review. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director will be in-serviced on or before 11/2/2024. This in-service will be conducted by the Executive Director and will include a review of NFPA 25, Standard for the Inspection, testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 13.6.2.1 and best documentation practices. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what	

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			quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will bring findings to the Quality Assurance and Performance Improvement Committee for review and follow-up. By what date the systemic changes will be completed: 11/7/2024 Compliance Date: 11/7/2024	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 1 of 1 electrical receptacle in the North pantry was protected. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect staff in the 200 hall. Findings include: Based on observation with the Maintenance Director from 12:41 p.m. to 3:00 p.m. on 10/17/24, the receptacle cover in the North pantry near the sink was missing. Based on interview at the time of the observation, the Maintenance Director stated he needed to get a cover on the receptacle.	K 0511	K511 – Utilities – Gas and Electric It is the practice of this facility to ensure all receptacles are protected in accordance with NFPA 70, 2011 Edition. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The electrical outlet in the North Pantry room has had a protective cover place over it. How other residents having the potential to be affected by the	11/07/2024

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	155219	A. BUILDING 01 B. WING	10/17/2024

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	This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this deficient practice. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director will be in-serviced on or before 11/2/2024. This in-service will be conducted by the Executive Director and will include a review of NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates) and best documentation practices. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The	

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			Maintenance Director/Designee will be responsible for completing QAPI audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. By what date the systemic changes will be completed: 11/7/2024 Compliance Date: 11/7/2024	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills for 2 of 3 shifts in 1 of 4 quarters and 1 of 3 shifts in 2 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director from 9:40 a.m. to 12:40 p.m. on 10/17/24, there was no documentation for a first shift fire drill in the third quarter of 2024; a third shift fire drill in the second quarter of 2024; a third shift fire drill in third quarter of 2024; or a third shift fire drill in the fourth quarter of 2023 or	K 0712	K712 – Fire Drills It is the practice of this facility to ensure the fire drills are completed in accordance with NFPA 101, Code 19.7.1.4 – 19.7.1.7. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Maintenance Director/designee has conducted fire drills in accordance with NFPA 101, Code 19.7.1.4 – 19.7.1.7. The Maintenance Director was	11/07/2024

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	2024. Based on record review and interview at the time of record review, the Maintenance Director stated he did not have documentation of fire drills conducted during the aforementioned shifts and did not state with certainty if the drills had been conducted. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b) 3.1-51(c)		unable to download these documents during the life safety survey. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this deficient practice. The Maintenance Director/Designee will be responsible for ensuring fire drills are properly scheduled and documented through TELS. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director will be in-serviced on or before 11/2/2024. This in-service will be conducted by the Executive Director and will include a review of NFPA 101, Code 19.7.1.4 – 19.7.1.7, and best documentation practices. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored	

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			though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will bring findings to the Quality Assurance and Performance Improvement Committee for review and follow-up. By what date the systemic changes will be completed: 11/7/2024 Compliance Date: 11/7/2024	
K 0761 SS=F Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on record review and interview, the facility failed to ensure annual inspection and testing of fire door assemblies were completed in accordance with LSC 8.3.3.1. LSC 8.3.3.1 states 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:	K 0761	K761 – Maintenance, Inspection, & Testing- Doors It is the practice of this facility to ensure maintenance, inspection, and testing of fire doors and fire door assemblies in accordance with NFPA 80.5.2.1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Maintenance Director has completed testing of all fire doors and fire door assemblies in accordance with NFPA 80.5.2.1. This documentation is uploaded to TELS. How other residents having the potential to be affected by the	11/07/2024

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	(1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director from 9:40 a.m. to 12:40 p.m. on 10/17/24, the facility was not able to provide completed fire door assembly inspections. Based on interview the Maintenance Director acknowledged documentation was not available and wrote a list of documents that he was not able to produce during survey.		same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this deficient practice. The Maintenance Director/Designee will be responsible for ensuring fire doors and fire door assemblies are properly scheduled and documented through TELS. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director will be in-serviced on or before 11/2/2024. This in-service will be conducted by the Executive Director and will include a review of NFPA 80.5.2.1 and best documentation practices. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will bring findings to the Quality Assurance and Performance	

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	This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		Improvement Committee for review and follow-up. By what date the systemic changes will be completed: 11/7/2024 Compliance Date: 11/7/2024	
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 all non-hospital-grade electrical receptacles at resident room locations 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, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director from 9:40 a.m. to 12:40 p.m. on 10/17/24, the facility was not able to provide documentation of annual testing of electrical	K 0914	K914 – Electrical Systems-Maintenance and Testing It is the practice of this facility to ensure that all non-hospital-grade receptacles are tested at least annually in accordance with NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 and Section 6.3.3.2. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The maintenance director/designee will ensure that all non-hospital-grade receptacles are tested at least annually in accordance with NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 and Section 6.3.3.2, and ensure that documentation is uploaded to TELS. All non-hospital grade receptacles will be tested no later than 11/7/2024.	11/07/2024

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	receptacles. Based on observation with the Maintenance Director from 12:41 p.m. to 3:00 p.m on 10/17/24, non-hospital-grade electrical receptacles were in use in all resident rooms throughout the facility. Based on interview, the Maintenance Director acknowledged the missing documentation and wrote a list of missing documentation. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this deficient practice. The Maintenance Director/Designee will be responsible for ensuring all non-hospital-grade receptacles are tested and properly scheduled/documented through TELS. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director will be in-serviced on or before 11/2/2024. This in-service will be conducted by the Executive Director and will include a review of NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 and Section 6.3.3.2 and best documentation practices. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance	

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			Improvement Program. The Maintenance Director/Designee will bring findings to the Quality Assurance and Performance Improvement Committee for review and follow-up. By what date the systemic changes will be completed: 11/7/2024 Compliance Date: 11/7/2024	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA-70 2011 Edition, 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 1 resident in room 203. Findings include: Based on observation and interview with the Maintenance Director from 12:41 p.m. to 3:00 p.m. on 10/17/24, an extension cord was being used in resident room 203 to provide power to a phone charger. Based on observation and interview the Maintenance Director acknowledged the extension cord and removed it at the time of observation. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)	K 0920	K920 – Electrical Equipment-Power Cords and Extension Cords It is the practice of this facility to ensure extension cords and power strips are not used as a substitute for fixed wiring to provide power to equipment. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1 Extension cord in room 203 was removed and the device was plugged into an appropriate power source. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:	11/07/2024

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			All residents have the potential to be affected by this deficient practice. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months which will include checks for various rooms and office to ensure compliance with extension cords and power strips. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All staff will be in-serviced on or before 11/7/2024. This in-service will be conducted by the Maintenance Director or Designee and will include a review of extension cords and power strip usage. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this	

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			corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. By what date the systemic changes will be completed: 11/7/2024 Compliance Date: 11/7/2024	