STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155269	A. BUILDING -- B. WING	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAST LAKE NURSING & REHABILITATION CENTER	1900 JEANWOOD DR ELKHART, IN 46514

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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: 02/27/2025 Facility Number: 000169 Provider Number: 155269 AIM Number: 100267100 At this Emergency Preparedness survey, East Lake Nursing and Rehabilitation was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 152 and had a census of 101 at the time of this survey. Quality Review completed on 02/28/25	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/27/2025 Facility Number: 000169 Provider Number: 155269 AIM Number: 100267100 At this Life Safety Code survey, East Lake	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
McKenzie Hojara	Executive Director	03/13/2025

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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	Nursing and Rehabilitation 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 monitored fire alarm system with hard-wire smoke detection in the corridors, areas open to the corridors and hardwired smoke detectors in the resident rooms. The facility has a capacity of 152 and had a census of 101 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 02/28/25			
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress 1.) Based on observation and interview, the facility failed to ensure continuity of egress lighting for 1 of 9 exits. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways and exit passageways leading to a public way. This deficient practice could affect residents, staff and visitors in the 500 hall. Findings include: Based on observation and interview with the Executive Director, Administrator-In-Training, and	K 0281	It is the practice of the facility to ensure continuity of egress lighting for exits. The exit discharge sidewalk leading to the public way from the 500 hall had exit lighting added to ensure adequate illumination. Egress lighting of the identified of exit to include multiple lights per sign. All residents, staff and visitors in the 500 hall have the potential to be affected by this deficient practice. A facility audit will be conducted on exit discharge	03/27/2025

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	the Maintenance Director from 11:47 a.m. to 2:45 p.m. on 02/27/25, the exit discharge sidewalk leading to a public way from the 500 hall, had a single egress light at the exit door of the 500 hall and again at the exit door of the 600 hall; however, based on interview at the time of observation the Maintenance Director stated the distance was approximately 80 feet that was not illuminated. Based on interview at time of observation the Maintenance Director stated the parking lights were on generator but acknowledged the lights did not illuminate the entire sidewalk. 2.) Based on observation and interview, the facility failed to ensure the egress lighting for 1 of 9 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect all residents, staff and visitors in the 500 hall. Findings include: Based on observation and interview with the Executive Director, Administrator-In-Training, and the Maintenance Director from 11:47 a.m. to 2:45 p.m. on 02/27/25, the exit means of egress outside the 500 hall exit, was equipped with one light fixture with only one bulb. This was acknowledged by the Maintenance Director at the time of each observation. These findings were reviewed with the Executive Director, Administrator-In-Training, and the Maintenance Director at the exit conference.		lighting to ensure adequate illumination on or before 3/27/25. A facility audit was conducted to ensure egress lighting sign has multiple lights. Maintenance Director/designee will complete a facility wide audit on or before 3/27/25 to ensure no other exit lighting pathways are improperly illuminated and exit signs are appropriately illuminated. All staff to be in-service on adequate exterior lighting on pathways on or before 3/27/25. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Supervisor/designee will be responsible for completing the QAPI Audit tool “Life Safety Code” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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K 0293 SS=E Bldg. 01	3.1-19(b) NFPA 101 Exit Signage Based on observation and interview; the facility failed to install exit signage in the 2 corridors and from 1 dining room in the facility in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect residents, staff and visitors in 2 of 7 smoke compartments. Findings include: Based on observation and interview with the Executive Director, Administrator-In-Training, and the Maintenance Director from 11:47 a.m. to 2:45 p.m. on 02/27/25, 1.) the corridor exit near the vending machines that led to the rear of the building had no signage indicating an exit. 2.) the corridor between the corridor smoke barrier	K 0293	It is the practice of the facility to ensure exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. Exit signage was added to the corridor exit near the vending machines. Exit signage was added to the corridor between the corridor smoke barrier doors and the unit corridor separation doors, between rooms 101 and 102. The door leading from the memory care unit to an enclosed courtyard had signage added indicating no exit. All residents, staff and visitors in the facility have the potential to be affected by this deficient practice. A facility audit will be conducted on or before 3/27/25 to ensure proper exit signage is present. Maintenance Director/designee will complete a facility audit to ensure proper exit signage is present. All staff to be in-service on proper exit signage on or before 3/27/25. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance	03/27/2025

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	doors and the unit corridor separation doors, between rooms 101 and 102 on the memory care unit had no exit signage. 3.) the door leading from the memory care unit to an enclosed courtyard had no signage indicating NO EXIT. Based on interview at the time of observation, the Maintenance Director acknowledged and confirmed that the path of egress was not obvious and contained no exit signage for the 2 corridor exits and no signage indicating the door from the memory care unit dining room to the courtyard was not an exit. This finding was reviewed with the Executive Director, Administrator-In-Training, and the Maintenance Director at the exit conference. 3.1-19(b)		Supervisor/designee will be responsible for completing the QAPI Audit tool “Life Safety Code” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities 1.) 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.	K 0324	It is the practice of the facility to maintain the kitchen extinguishing system. The pull station was moved to a height between 42 in and 48 in. The kitchen range hood nozzle was moved to be properly positioned. All kitchen staff have the potential to be affected by this deficient practice. A facility audit will be conducted on or before 3/27/25 to ensure pull stations are properly maintained and kitchen range hood nozzles are properly positioned. The Maintenance	03/27/2025

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	Findings include: Based on observation and interview with the Executive Director, Administrator-In-Training, and the Maintenance Director from 11:47 a.m. to 2:45 p.m. on 02/27/25, the kitchen hood fire suppression system "Pull Station" was mounted 61 1/2 inches above the floor near the door leading out of the kitchen. Based on interview at the time of observation, the Maintenance Director observed the measurement taken with a tape measure and acknowledged the pull station was mounted with the center of the pull station handle at 61 ½ inches above the floor. 2.) Based on observation and interview, the facility failed to ensure 1 of 1 kitchen range hood extinguishing systems was maintained in proper working order. NFPA 96, 2011 edition, Section 10.1.2 requires 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. Section 11.1.6 states cooking equipment shall not be operated while its fire-extinguishing system or exhaust system is non-operational or impaired. This deficient practice could affect kitchen staff only. Findings include: Based on observation and interview with the Executive Director, Administrator-In-Training, and the Maintenance Director from 11:47 a.m. to 2:45 p.m. on 02/27/25, the kitchen range hood extinguishing system nozzles were not properly positioned over the cooking equipment under the hood. 1 of 3 nozzles were pointed at a shelf above the cooking equipment. The Maintenance Director acknowledged the nozzle was positioned		Director/designee will complete a facility audit to ensure pull stations are properly maintained and kitchen range hood nozzles are properly positioned. All staff to be in-service on pull stations and kitchen range hood nozzles on or before 3/27/25. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Supervisor/designee will be responsible for completing the QAPI Audit tool “Life Safety Code” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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	over the cooking equipment but pointed to the shelf above the equipment. These findings were reviewed with the Executive Director, Administrator-In-Training, and the Maintenance Director at the exit conference. 3.1-19(b)			
K 0341 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Installation Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm control panels were protected. LSC 19.3.4.1 states health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. LSC 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, Section 10.10.1 states a means for turning off activated alarm notification appliance(s) shall be permitted only if it complies with 10.10.3 through 10.10.7. Section 10.10.3 states the means shall be key-operated or located within a locked cabinet or arranged to provide equivalent protection against unauthorized use. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation and interview with the Executive Director, Administrator-In-Training, and the Maintenance Director from 11:47 a.m. to 2:45 p.m. on 02/27/25, fire control annunciator panels were located at: 1) the receptionist desk,	K 0341	It is the practice of the facility to ensure the fire alarm control panels are protected. The keys in the fire annunciator panels were removed. All residents, staff and visitors have the potential to be affected by this deficient practice. A facility audit will be conducted on or before 3/27/25 to ensure the fire control panels were properly secured with no keys present. The Maintenance Director/designee will complete a facility audit to ensure the fire control panels were properly secured with no keys present. All staff to be in-service on the fire control panels being properly secured with no keys present on or before 3/27/25. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance	03/27/2025

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	2) unit 1 nurses station, and 3) the unit 2 nurses station. All three fire control annunciator panels were in cabinets, but the doors to the cabinets were locked with the key in the lock. This condition does not protect the fire alarm system against unauthorized use. Based on interview at the time of observations, the House Manager agreed the cabinet door to the fire control panel was not properly secured because the key was in the lock of the door. This finding was reviewed with the Executive Director, Administrator-In-Training, and the Maintenance Director at the exit conference. 3.1-19(b)		Supervisor/designee will be responsible for completing the QAPI Audit tool “Life Safety Code” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1.) Based on observation and interview, the facility failed to ensure all sprinkler heads were not loaded or covered with foreign material in accordance with LSC 9.7.5. 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 residents, staff, and visitors. Findings include:	K 0353	It is the practice of the facility to ensure all sprinkler heads are not loaded or covered with foreign materials and paint and to ensure sprinkler cabinet has quick response sprinkler present. Sprinkler head located in main dining room was changed to ensure no paint on deflector. The spare sprinklers in the spare sprinkler cabinet were updated to include quick response sprinklers. All staff, residents and visitors have the potential to be affected by this deficient practice. A facility audit will be conducted on or before 3/27/25 to ensure sprinkler heads are not loaded or covered in	03/27/2025

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	Based on observation and interview with the Executive Director, Administrator-In-Training, and the Maintenance Director from 11:47 a.m. to 2:45 p.m. on 02/27/25, one sprinkler head located in the main dining room outside of the kitchen entrance had paint on the deflector. Based on interview the Maintenance Director acknowledged the paint on the sprinkler deflector but could not explain the reason for the paint. 2.) Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was maintained with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. Section 5.4.1.4.1 states the sprinklers shall correspond to the types and temperature ratings of the sprinklers in the property. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observation and interview with the Executive Director, Administrator-In-Training, and the Maintenance Director from 11:47 a.m. to 2:45 p.m. on 02/27/25, there were spare standard response sprinkler heads available but there were no spare quick response sprinklers in the cabinet. Based on observation throughout the facility most of the facility had standard response sprinkler heads, but the kitchen contained quick response sprinkler heads. Based on interview at		foreign material, no paint is present and quick response sprinklers are in sprinkler cabinet. The Maintenance Director/designee will complete a facility audit to ensure sprinkler heads are not loaded or covered in foreign material, no paint is present and quick response sprinklers are in sprinkler cabinet. All staff to be in-service on sprinkler heads are not being loaded or covered in foreign material, no paint is present and quick response sprinklers are in sprinkler cabinet on or before 3/27/25. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Supervisor/designee will be responsible for completing the QAPI Audit tool “Life Safety Code” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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	the time of the observation, the Maintenance Director acknowledged the spare sprinkler cabinet contained all the same type of sprinkler heads These findings were reviewed with the Executive Director, Administrator-In-Training, and the Maintenance Director at the exit conference. 3.1-19(b)			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to ensure 1 of 3 portable fire extinguishers in the kitchen were installed in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than five feet above the floor. This deficient practice could affect kitchen staff. Findings include: Based on observation and interview with the Executive Director, Administrator-In-Training, and the Maintenance Director from 11:47 a.m. to 2:45 p.m. on 02/27/25, the ABC dry chemical type portable fire extinguisher located in the kitchen was located inside a cabinet that was surface mounted to the wall with the top of the extinguisher 5 feet 8 inches above the floor. Based on interview at the time of observation, the Maintenance Director observed the measurement taken with a tape measure and acknowledged the fire extinguisher was mounted with the top of the extinguisher greater than five feet above the floor.	K 0355	It is the practice of the facility to ensure all portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. The deficient portable fire extinguisher affecting kitchen staff was installed so that the top of the fire extinguisher is not more than five feet above the floor. All staff and residents have the potential to be affected by this deficient practice. A facility audit will be conducted on or before 3/27/25 to ensure all portable fire extinguishers are installed to be no more than five feet above the floor. The Maintenance Director/designee will complete a facility audit to ensure that all portable fire extinguishers are installed to be no more than five feet above the floor. All staff to be	03/27/2025

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	This finding was reviewed with the Executive Director, Administrator-In-Training, and the Maintenance Director at the exit conference. 3.1-19(b)		in-service on the portable fire extinguishers heights on or before 3/27/25. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Supervisor/designee will be responsible for completing the QAPI Audit tool "Life Safety Code" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors 1.) Based on observation and interview, the facility failed to ensure 3 of 12 resident room doors in 1 of 7 smoke compartments were maintained in accordance with LSC Section 19.3.6.3. Section 19.3.6.3.5 states that corridor doors shall be provided with a means for keeping the door closed. Section 19.3.6.3.10 states that doors shall not be held open by devices other than those that release when the door is pushed or pulled. This deficient practice could affect residents, staff, and visitors in 1 of 7 smoke compartments. Findings include: Based on observation and interview with the Executive Director, Administrator-In-Training, and	K 0363	It is the practice of the facility to ensure the resident room doors are maintained. Room 301, 304 and 305 were fixed to ensure proper latching. The ¼-1/2 inch hold above the door in room 512 was fixed to ensure no hole present. All staff and residents have the potential to be affected by this deficient practice. A facility audit will be conducted on or before 3/27/25 to ensure all doors maintain proper latching and there are no holes in fire doors. The Maintenance Director/designee will complete a	03/27/2025

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	the Maintenance Director from 11:47 a.m. to 2:45 p.m. on 02/27/25, the corridor doors to resident rooms 301, 304 and 305 failed to latch after the Maintenance Director made several attempts to close and latch the doors. The Maintenance Director and Executive Director removed tissue paper from the door latch from resident room door 305; however, the door failed to latch after they removed the material. Based on interview at the time of observation, the Maintenance Director acknowledged the doors did not latch 2.) Based on observation and interview, the facility failed to ensure 1 of 1 door to the corridor would completely resist the passage of smoke. Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. This deficient practice could affect residents, staff, and visitors in 1 of 7 smoke compartments. Findings include: Based on observation and interview with the Executive Director, Administrator-In-Training, and the Maintenance Director from 11:47 a.m. to 2:45 p.m. on 02/27/25, the door to room 512 had approximately ¼-½ inch hole above the door handle. The Maintenance Director observed the measurement taken with a tape measurement and stated the hole was about ½ inch. This finding was reviewed with the Executive Director, Administrator-In-Training, and the Maintenance Director at the exit conference.		facility audit to ensure all doors maintain proper latching and there are no holes in fire doors. All staff to be in-service on the all doors maintain proper latching and there are no holes in fire doors on or before 3/27/25. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Supervisor/designee will be responsible for completing the QAPI Audit tool “Life Safety Code” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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K 0372 SS=E Bldg. 01	3.1-19(b) NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 6 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect residents, staff and visitors in 2 of 7 smoke compartments. Findings include: Based on observation and interview with the Executive Director, Administrator-In-Training, and the Maintenance Director from 11:47 a.m. to 2:45 p.m. on 02/27/25, an unsealed penetration approximately 3 inches by 1 inch was discovered above the smoke barrier doors in the main hall between the MDS office and Activity room. The Maintenance Director acknowledged the penetration and stated the penetrations was about 3 inches. This finding was reviewed with the Executive Director, Administrator-In-Training, and the Maintenance Director at the exit conference. 3.1-19(b)	K 0372	It is the practice of the facility to ensure penetration of the smoke barrier wall by wire and/or conduit be protected to maintain smoke resistance. Two of seven smoke compartments were found deficient in the practice, unsealed penetration areas have been sealed in accordance with LSC Section 8.5. All residents, staff and visitors in the two of seven smoke compartments have the potential to be affected by this deficient practice. A facility audit will be conducted on smoke barrier penetrations to ensure the penetrations caused by the passage of wire and/or conduit are protected to maintain smoke resistance of each smoke barrier on or before 3/27/25. Maintenance Director/designee will complete a facility wide audit to ensure penetrations caused by the passage of wire and/or conduit are protected to maintain smoke resistance of each smoke barrier. All staff to be in-service on smoke barrier penetrations on or before 3/27/25. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance	03/27/2025

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			Improvement Program (QAPI). The Maintenance Supervisor/designee will be responsible for completing the QAPI Audit tool “Life Safety Code” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric 1.) Based on observation and interview, the facility failed to ensure 1 of 1 wet location in the restroom located in the kitchen and 1 of 1 wet location in the activity room was provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops	K 0511	It is the practice of the facility to ensure equipment using gas or related piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. The wet location in restroom in kitchen was replaced with GFCI protection outlet. The outlet receptacle faceplate located in unit 2 med room was replaced. All kitchen staff and unit 2 staff could be affected by this deficient practice. A facility audit will be conducted on ensuring proper electrical receptacles are maintained and outlet receptacle faceplates are maintained on or before 3/27/25. Maintenance Director/designee will complete a facility wide audit to ensure proper electrical receptacles are maintained and outlet receptacle faceplates are	03/27/2025

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	(4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit		maintained. All staff to be in-service on ensuring proper electrical receptacles are maintained and outlet receptacle faceplates are maintained on or before 3/27/25. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Supervisor/designee will be responsible for completing the QAPI Audit tool “Life Safety Code” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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	interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff in the kitchen only. Findings include: Based on observation and interview with the Executive Director, Administrator-In-Training, and the Maintenance Director from 11:47 a.m. to 2:45 p.m. on 02/27/25, 1.) one electrical receptacle 10 inches of the sink in the restroom located in the kitchen. The electric receptacle was not provided with ground fault circuit interrupter (GFCI). The electrical receptacle was a standard type and when tested failed to interrupt service when tested. Based on interview the Maintenance Director stated he didn't understand why it didn't work since the electrical receptacle had a green dot located on it. 2.) one ground-fault circuit interrupter (GFCI) type electrical receptacle located 44 inches from a sink in the activity room failed to interrupt service when tested. #2) Based on observation and interview, the facility failed to ensure 1 of 1 electrical receptacles 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 Unit 2 med room. Findings include: Based on observation and interview with the Executive Director, Administrator-In-Training, and the Maintenance Director from 11:47 a.m. to 2:45 p.m. on 02/27/25, the receptacle cover in the med			

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	room located at Unit 2 nurses station was missing. Based on observation a refrigerator was plugged into the receptacle at the time. Based on interview, the Maintenance Director acknowledged the missing cover and exposed wiring. This finding was reviewed with the Executive Director, Administrator-In-Training, and the Maintenance Director at the exit conference. 3.1-19(b)			
K 0522 SS=E Bldg. 01	NFPA 101 HVAC - Any Heating Device Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms were provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for all staff in the laundry room. Findings include: Based on observation and interview with the Executive Director, Administrator-In-Training, and the Maintenance Director from 11:47 a.m. to 2:45 p.m. on 02/27/25, the laundry room had a natural gas fuel-fired water heater without a fresh air intake. The water heater was located in the soiled side of the laundry room which was separated from the clean side of the laundry room by a separation wall that included a door. This condition does not allow fresh air to completely enter the room. Based on an interview at the time of observation, three ceiling vents were present; however, the Maintenance Director stated he did not know if any of the three ceiling vents	K 0522	It is the practice of the facility to ensure any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. The facility was deficient in providing 1 of 1 laundry rooms containing fuel fired equipment with intake combustion air from outside. Facility contracted with servicer resulting in installation of air intake vent to deliver outside air to laundry room containing fuel fired equipment. All laundry staff have the potential to be affected by this deficient practice. A facility audit will be conducted reviewing all fuel fired equipment to ensure proper outside ventilation is in place and	03/27/2025

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	provided fresh air . This finding was reviewed with the Executive Director, Administrator-In-Training, and the Maintenance Director at the exit conference. 3.1-19(b)		functional on or before 3/27/25. Maintenance Director/designee will complete a facility wide audit to ensure proper outside ventilation is in place and functional on or before 3/27/25. All staff to be in-service on proper fuel fired equipment ventilation practices on or before 3/27/25. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Supervisor/designee will be responsible for completing the QAPI Audit tool “Life Safety Code” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure flexible cords and adapters were not used as a substitute for fixed wiring in 2 of 7 smoke compartments. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, 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. This deficient practice could affect residents and staff in 1 of 7 smoke compartments.	K 0920	It is the practice of the facility to ensure power strips utilized in patient care rooms are compliant with National Electrical Code. The deficient practice identified in 2 of 7 smoke compartments was corrected by removing the power strips with an unknown rating. All residents, staff and visitors in the 2 of 7 smoke compartments have the potential to be affected	03/27/2025

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	Findings include: Based on observation and interview with the Executive Director, Administrator-In-Training, and the Maintenance Director from 11:47 a.m. to 2:45 p.m. on 02/27/25, a power strip with an unknown rating was supplying power to Pace Maker monitor, a fan, and a night light. This finding was reviewed with the Executive Director, Administrator-In-Training, and the Maintenance Director at the exit conference. 3.1-19(b)		by this deficient practice. A facility audit will be conducted reviewing all power strips ensuring compliance with National Electrical Code on or before 3/27/25. Power strips with unknown ratings will be removed. Maintenance Director/designee will complete a facility wide audit to ensure all power strips in utilization are compliance rate in accordance with National Electrical Code. All staff to be in-service on proper power strip utilization compliance with National Electrical Code on or before 3/27/25. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Supervisor/designee will be responsible for completing the QAPI Audit tool “Life Safety Code” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	