STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING -- B. WING	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(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: 03/31/25 Facility Number: 000134 Provider Number: 155229 AIM Number: 100275430 At this Emergency Preparedness survey, The Woodlands was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 108 certified beds. At the time of the survey, the census was 76. Quality Review completed on 04/04/25	E 0000	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because The Woodlands agrees with the allegations and citations listed. The Woodlands maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.1 Develop EP Plan, Review and Update Annually Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 03/31/25 at 11:30 a.m., there was no annual review date in the EPP provided, and no	E 0004	E004 – Develop EP Plan, Review and Update Annually – **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** No residents were identified **How other residents having the potential to be affected by the same alleged deficient practice**	04/30/2025

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

Kevin Spaugh | Executive Director | 04/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	other documentation could be found to show if the EPP was reviewed and updated within the last year. Based on an interview at 11:30 a.m., the Maintenance Director stated the documentation to show if the EEP has been reviewed or updated within the last year could not be found. This finding was reviewed with the Maintenance Director during the exit conference at 3:00 p.m.		**will be identified and what corrective action will be taken:** A one-time review of current resident population has been completed with no findings. **What measures will be into place of what systemic changes will be made to ensure that the deficient practice does not recur:** The facility has updated the Emergency Preparedness plan review for the current year. The EP plan will be reviewed, updated as necessary, and trained upon, in January of each calendar year. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The facility Executive Director will conduct an Audit in January, each calendar year, to ensure the EP has been implemented, updated, trained on, and signed for each new calendar year.	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.1 Development of EP Policies and Procedures Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance	E 0013	E013 Development of EP Policies and Procedures **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** No residents were identified **How other residents having the potential to be affected by the**	04/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Director on 03/31/25 at 11:30 a.m., there was no annual review date in the EPP provided, and no other documentation could be found to show if the EPP Policies and Procedures were reviewed and updated within the last year. Based on an interview at 11:30 a.m., the Maintenance Director stated the documentation to show if the EEP Policies and Procedures have been reviewed or updated within the last year could not be found. This finding was reviewed with the Maintenance Director during the exit conference at 3:00 p.m.		**same alleged deficient practice will be identified and what corrective action will be taken:** A one-time review of current resident population has been completed with no findings. **What measures will be into place of what systemic changes will be made to ensure that the deficient practice does not recur:** The facility has updated the Emergency Preparedness plan review for the current year. The EP plan will be reviewed, updated as necessary, and trained upon, in January of each calendar year. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The facility Executive Director will conduct an Audit in January, each calendar year, to ensure the EP has been implemented, updated, trained on, and signed for each new calendar year.	
E 0025 SS=F Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b) Arrangement with Other Facilities Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) including the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents. Policies and Procedures must be reviewed and updated annually for LTC facilities	E 0025	E 025 – Arrangement with Other Facilities **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** No residents were identified **How other residents having the**	04/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	accordance with 42 CFR 483.73(b)(7). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 03/31/25 at 11:45 a.m., the documentation for arrangements with other LTC facilities had review dates of 2017 and 2018, there was no annual review date for the EPP provided, and no other documentation could be found to show if the EPP was reviewed and updated within the last year. Based on an interview at 11:45 a.m., the Maintenance Director stated the documentation to show if the EEP aid agreements have been reviewed or updated within the last year could not be found. This finding was reviewed with the Maintenance Director during the exit conference at 3:00 p.m.		**potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken:** Residents in need of transport to alternate facility. Current Transfer Agreements in place have been reviewed, and updated for the current year. **What measures will be into place of what systemic changes will be made to ensure that the deficient practice does not recur:** The facility has updated the Emergency Preparedness plan review for the current year. The EP plan will be reviewed, updated as necessary, and trained upon, in January of each calendar year. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The facility Executive Director will conduct an Audit in January, each calendar year, to ensure the EP has been implemented, updated, trained on, and signed for each new calendar year. Transfer agreements will be audited in January each calendar year, and updated as necessary.	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.1 Development of Communication Plan Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Communication Plan at	E 0029	E 0029 – Development of Communication Plan **What corrective action will be**	04/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 03/31/25 at 11:30 a.m., there was no annual review date in the EPP provided, and no other documentation could be found to show if the EPP Communication Plan was reviewed and updated within the last year. Based on an interview at 11:30 a.m., the Maintenance Director stated the documentation to show if the EEP Communication Plan has been reviewed or updated within the last year could not be found. This finding was reviewed with the Maintenance Director during the exit conference at 3:00 p.m.		**accomplished for those residents found to have been affected by the alleged deficient practice?** No residents were identified **How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken:** A one-time review of current resident population has been completed with no findings. **What measures will be into place of what systemic changes will be made to ensure that the deficient practice does not recur:** The facility has updated the Emergency Preparedness plan review for the current year. The EP plan will be reviewed, updated as necessary, and trained upon, in January of each calendar year. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The facility Executive Director will conduct an Audit in January, each calendar year, to ensure the EP has been implemented, updated, trained on, and signed for each new calendar year.	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.1 EP Training and Testing Based on record review and interview, the facility failed to review and update the Emergency	E 0036	E 036 – EP Training and Testing **What corrective action will be**	04/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	Preparedness Plan (EPP) Training and Testing Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 03/31/25 at 11:30 a.m., there was no annual review date in the EPP provided, and no other documentation could be found to show if the EPP Training and Testing Plan was reviewed and updated within the last year. Based on an interview at 11:30 a.m., the Maintenance Director stated the documentation to show if the EEP Training and Testing Plan has been reviewed or updated within the last year could not be found. This finding was reviewed with the Maintenance Director during the exit conference at 3:00 p.m.		**accomplished for those residents found to have been affected by the alleged deficient practice?** No residents were identified **How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken:** A one-time review of current resident population has been completed with no findings. **What measures will be into place of what systemic changes will be made to ensure that the deficient practice does not recur:** The facility has updated the Emergency Preparedness plan review for the current year. The EP plan will be reviewed, updated as necessary, and trained upon, in January of each calendar year. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The facility Executive Director will conduct an Audit in January, each calendar year, to ensure the EP has been implemented, updated, trained on, and signed for each new calendar year.	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(EP Training Program Based on record review and interview, the facility failed to conduct annual training for the	E 0037	**What corrective action will be accomplished for those**	04/30/2025

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K 0000 Bldg. 01	Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Maintenance Director on 03/31/25 at 11:50 a.m., no documentation of annual EEP training and no documentation to show staff could demonstrate knowledge of the EPP was available for review. Based on an interview at 11:50 a.m., the Maintenance Director stated the EPP training was not conducted within the last year. This finding was reviewed with the Maintenance Director during the exit conference at 3:00 p.m.		**residents found to have been affected by the alleged deficient practice?** No residents were identified **How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken:** A one-time review of current resident population has been completed with no findings. The facility will have staff trained on the EP for current calendar year by compliance date below. **What measures will be into place of what systemic changes will be made to ensure that the deficient practice does not recur:** The facility has updated the Emergency Preparedness plan review for the current year. The EP plan will be reviewed, updated as necessary, and trained upon, in January of each calendar year. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The facility Executive Director will conduct an Audit in January, each calendar year, to ensure the EP has been implemented, updated, trained on, and signed for each new calendar year.	

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	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: 3/31/25 Facility Number: 000134 Provider Number: 155229 AIM Number: 100275430 At this Life Safety Code survey, The Woodlands 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 (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, battery powered smoked detectors in all resident sleeping rooms and spaces open to the corridors. The facility has a capacity of 108 and had a census of 76 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has three sheds and one pod providing storage which were not sprinklered Quality Review completed on 04/04/25	K 0000	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because The Woodlands agrees with the allegations and citations listed. The Woodlands maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility	K 0324	K324 – Cooking Facilities	04/30/2025

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	failed to provide an approved method for returning cooking appliances to the designed and installed positions for 1 of 1 kitchen hood extinguishing system. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2, states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 states the fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 states an approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice affects staff in the kitchen and 30 residents in the main dining room. The findings include: Based on observation with the Maintenance Director on 03/31/25 at 1:20 p.m., the cooking equipment in the main kitchen was covered by the fire suppression system, but the kitchen was not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. Based on an interview at 1:20 p.m., the Maintenance Director agreed the kitchen was not provided with an approved method that would ensure that the		**What corrective action will be accomplished for those residents found to be affected by the alleged deficient practice?** No residents were identified. The facility Maintenance Director or designee will be present during scheduled hood cleanings to ensure cooking equipment is replaced to its proper position. **How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken:** The facility Maintenance Director has been educated on the proper placement of cooking equipment following scheduled cleaning. Additionally, Dietary staff educated on proper placement of cooking equipment. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of the facility Maintenance and Dietary staff to ensure cooking equipment is properly place following scheduled cleaning. The facility ED will audit the cooking equipment area following each scheduled cleaning to ensure equipment has been properly replaced. **How the corrective action will be monitored to ensure the deficient practice will not**	

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	appliances were returned to an approved design location after they had been moved for maintenance and cleaning. The findings were reviewed with the Maintenance Director during the exit conference at 3:00 p.m. 3.1-19(b)		**recur:** The facility maintenance director, or designee, will be present in facility when scheduled cleaning is completed to ensure cooking equipment is properly re-placed. Facility Executive Director will audit cooking equipment placement following each scheduled cleaning to ensure proper re-placement.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems were continuously in proper operating condition. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation of the fire alarm control panel (FACP) with the Maintenance Director on 03/31/25 at 12:56 p.m., the FACP display indicated the date as 09/03 and indicated the time as 08:21 a.m., when checked on 03/31/25 at 12:56 p.m. Based on interview at 12:56 p.m., the Maintenance Director agreed the FACP had the wrong time and date. This finding was reviewed with the Maintenance Director during the exit conference at 3:00 p.m. 3.1-19(b)	K 0345	K 345 – Fire Alarm System – Testing and Maintenance **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** No residents were identified. The facility corrected the date and time display on the date of survey. **How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken:** The facility maintenance director, or designee, will monitor the fire alarm panel M-F to ensure date and time display are accurate. **What measures will be put into place or what systemic changes will be made to ensure the alleged deficient practice does not recur:** The facility Executive Director will	04/30/2025

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			audit the fire alarm panel displayed time and date weekly for three months to ensure correct display. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The facility Executive Director will monitor the fire alarm panel display readings weekly times 3 months to ensure compliance.	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Based on record review and interview, the facility failed to provide 1 of 1 correct written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty-four-hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review with the Maintenance Director on 03/31/25 at 12:38 p.m., the provided fire watch plan did not indicate staff conducting fire watches were trained on fire watch procedures, had no other duties while conducting a fire watch, and the plan only listed a phone number for IDOH and failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.health.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@health.in.gov. Based on	K 0346	K 346 – Fire Alarm – Out of Service **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** No residents were identified **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** The facility has updated the Fire Watch Plan to include the primary contact method to include the IDOH Gateway, and secondary contact method as telephone notification to the IDOH. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	04/30/2025

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	an interview at 12:38 p.m., the Maintenance Director agreed the fire watch documentation provided was missing training for staff and did not contain the complete IDOH Gateway link or the e-mail address listed above. This finding was reviewed with the Maintenance Director during the exit conference at 3:00 p.m. 3.1-19(b)		Facility policy has been updated to include the Gateway notification of Fire Watch. Facility staff educated on Fire Watch policy and procedure. **How the corrective action will be monitored to ensure the deficient practice does not recur:** The facility Fire Watch policy is updated to include Gateway as Primary notification. The facility Executive Director holds responsibility to make notifications to the IDOH in the event of Fire Watch. Facility policies are reviewed in January each calendar year, and Fire Watch policy will be audited at that time to ensure proper notification directions remain in the policy.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing (#1) Based on observation and interview, the facility failed to ensure 1 of 4 sprinklers in the laundry room were free of rust and foreign materials. NFPA 25, 2011 edition, at 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 states 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.	K 0353	K 353 – Sprinkler System – Maintenance and Testing **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** No residents were identified. The facility Maintenance Director has cleaned the 1 of 4 sprinklers in the laundry room identified as not free from rust and foreign materials. (2) The facility has replaced the signage on the outdoor fire department connections with a	04/30/2025

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WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

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	This deficient practice could affect 30 residents in one smoke compartment. (#2) Based on observation and interview, the facility failed to ensure 1 of 1 fire department connection sign was readable. NFPA 25 2010 edition states 13.7.1 fire department connections shall be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. This deficient practice could affect all residents. Findings include: (#1) Based on observation with the Maintenance Director on 03/31/25 at 1:53 p.m., the sprinkler head in south hall linen room was rusted and contained materials stuck to the sprinkler. Based on an interview at 1:53 p.m., the Maintenance Director agreed the sprinkler in south hall linen room was rusted and contained materials stuck to the sprinkler. (#2) Based on observations during a tour of the facility with the Maintenance Director on 03/31/25 at 1:17 p.m., there was a sign at the fire department connection, but the sign was faded and was not legible. Based on an interview at 1:17 p.m., the		new sign **How other residents having the potential to be affected by same deficient practice will be identified and what corrective action will be taken:** The facility maintenance director, or designee, will evaluate all facility sprinkler heads during routine monthly environmental rounds to identify any sprinkler heads in need of cleaning **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The facility maintenance director, or designee, will evaluate all facility sprinkler heads during routine monthly environmental rounds to identify any sprinkler heads in need of cleaning. The facility Executive Director will make rounds with the Maintenance Director as secondary monitoring. The facility maintenance director, or designee, will evaluate all facility sprinkler heads during routine monthly environmental rounds to identify any sprinkler heads in need of cleaning **How the corrective action will be monitored to ensure the deficient practice will not recur:** The facility Maintenance Director will evaluate during monthly environmental preventative	

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	Maintenance Director agreed the posted sign was faded and was hard to read. The findings were reviewed with the Maintenance Director during the exit conference at 3:00 p.m. 3.1-19(b)		maintenance rounding. The facility Executive Director will audit resulting cleaning of sprinkler heads as identified.	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Based on record review and interview, the facility failed to provide a complete written fire watch policy for the protection of residents, indicating procedures to be followed in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on records review with the Maintenance Director on 03/31/25 at 12:38 p.m., the provided fire watch plan did not indicate staff conducting	K 0354	**What corrective action will be accomplished for those residents found to be affected by the alleged deficient practice?** No residents were identified – The facility has updated the Fire Watch policy to include the correct notifications. Staff to be educated on the updated Fire Watch policy for proper safety monitoring of residents. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** The facility Fire Watch policy is updated with correct notification to the IDOH including the Gateway as primary notification method. Facility staff educated on the updated Fire Watch policy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Facility staff will be educated on	04/30/2025

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	fire watches were trained on fire watch procedures, had no other duties while conducting a fire watch, and the plan only listed a phone number for IDOH and failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.health.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@health.in.gov. Based on an interview at 12:38 p.m., the Maintenance Director agreed the fire watch documentation provided was missing training for staff and did not contain the complete IDOH Gateway link or the e-mail address listed above. This finding was reviewed with the Maintenance Director during the exit conference at 3:00 p.m.		Updated fire watch policy and procedure to be followed when system is out of service for 10 or more hours in a 24 hour period. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The facility Executive Director, or designee, will audit fire watch documentation if/when initiated to ensure proper monitoring and facilitation of Fire Watch Policy.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 2 of 3 kitchen corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching, and would resist the passage of smoke. This deficient practice could affect 30 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 03/31/25 at 1:14 p.m., the corridor kitchen dish room door and the side kitchen door were propped open with a fork and a wood block. Based on an interview at 1:14 p.m., the Maintenance Director agreed the corridor doors were propped open.	K 0363	F363 – Corridor Doors **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** No residents were identified. The facility secured the “propped” doors at the time of the survey. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** The facility identifies residents utilizing the dining room could have potential to be affected. The dietary staff to be educated on the	04/30/2025

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	This finding was reviewed with the Maintenance Director during the exit conference at 3:00 p.m. 3.1-19(b)		importance of NOT propping any doors in the kitchen area. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Dietary Manager, or designee, holds responsibility to ensure kitchen corridor doors are not propped open at any time. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The facility Executive Director will audit corridor doors to ensure no propping is occurring, weekly times three months.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 4 of 4 med-room receptacles within 6 feet from a sink were 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	K 0511	K511 – Utilities – Gas and Electric **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** No residents were identified. The facility maintenance director has replaced 4 of 4 med room receptacles with GFCI receptacles. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** The facility has replaced the	04/30/2025

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	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, (4) Outdoors, (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. (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. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have 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 5 residents in the therapy gym. This deficient practice could affect 40 residents in two smoke compartments. Findings include: Based on observations with the Maintenance Director on 03/31/25 at 1:43 p.m. and at 2:03 p.m., in the north and south med-rooms there were two electric receptacles within 3 feet from each sink. All four electric receptacles were not GFCI protected. Based on interviews at 1:43 p.m. and at 2:03 p.m., the Maintenance Director agreed the electric receptacles by the sinks in both med-rooms were not GFCI protected. The findings were reviewed with the Maintenance Director during the exit conference at 3:00 p.m. 3.1-19(b)		identified receptacles with GFCI receptacles. No other residents are identified. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The facility has replaced the identified receptacles with GFCI receptacles. The Maintenance Director will hold responsibility to ensure GFCI receptacles are in place and functioning properly through preventative maintenance rounds, monthly. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The facility Maintenance Director will monitor GFCI receptacles for proper functioning through preventative maintenance rounds weekly and monthly.	
K 0741 SS=E	NFPA 101 Smoking Regulations			

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Bldg. 01	Based on observation and interview, the facility failed to ensure 1 of 1 smoking areas was maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect staff by the staff exit. Findings include: Based on observation with the Maintenance Director on 03/31/25 at 1:40 p.m., outside of the employee exit had over 50 cigarette butts disposed on the ground around the exit and a shed. Based on an interview at 1:40 p.m., the Maintenance Director agreed there were cigarette butts on the ground outside of the employee exit. The findings were reviewed with the Maintenance Director during the exit conference at 3:00 p.m. 3.1-19(b)	K 0741	K741 – Smoking Regulations **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** No residents were identified. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** The facility has not identified any additional residents as being affected. Facility staff has been re-educated on facility smoking policies, and proper disposal of cigarette butts. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The facility staff will be re-educated on the facility smoking policy. The facility will take necessary disciplinary action if warranted, related to violations of facility smoking policy. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The facility Maintenance Director, or designee, will round the property outdoors on a daily basis, M-F, to ensure cigarette butts are not accumulating on the property. The Executive Director will round	04/30/2025

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			the outdoor property on a weekly basis to audit Maintenance Director monitoring.	
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation and interview, the facility failed to ensure 1 of 6 smoke barrier doors were routinely inspected and repaired as part of the facility maintenance program. This deficient practice could affect 35 residents in two smoke compartments. Findings include: Based on observation with the Maintenance Director on 03/31/25 at 2:28 p.m., the smoke doors by room 34 were damaged and had 12 screw holes that went halfway through the doors. Based on an interview at 2:28 p.m., the Maintenance Director agreed there were screw holes in the smoke doors by room 34. The findings were reviewed with the Maintenance Director during the exit conference at 3:00 p.m. 3.1-19(b)	K 0761	K761 – Maintenance, Inspection & Testing – Doors **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** No residents were identified. The facility Maintenance Director has repaired 1 of 6 smoke barrier doors found to have 12 screw holes in the smoke doors. All 12 screw holes have been properly sealed. **How other residents having potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** A one - time review of all smoke barrier doors has been completed to determine if any other smoke barrier doors are affected, there were no findings. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Staff will be educated on the importance of not penetrating smoke barrier doors for any reason. Maintenance Director, or	04/30/2025

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			designee, will hold responsibility to examine smoke barrier doors throughout the facility to ensure no doors have been altered, during weekly preventative maintenance rounding. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Executive Director, or designee, will monitor smoke barrier doors during daily rounding to ensure no damage or alterations to said doors has occurred.	
K 0916 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator annunciator panel was in proper operating condition. This deficient practice could affect all residents. Findings include: Based on observation with the Maintenance Director on 03/31/25 at 1:38 p.m., the generator's annunciator panel at the main nurse's station showed a communication alarm on the panel. Based on an interview at 1:38 p.m., the Maintenance Director stated the generator was working but the generator's annunciator panel was not working and there is not anther annunciator panel in the building. Also stated, the annunciator panel is currently being repaired but are waiting on a part for the annunciator panel.	K 0916	K916 – Electrical Systems – Essential Electric System **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** No residents were identified. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** It was explained to the surveyor on the date of survey that the Generator Panel was currently being serviced for the faulty alarm, and a part was ordered for the effective repair. The part was not yet available at time of survey.	04/30/2025

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	The findings were reviewed with the Maintenance Director during the exit conference at 3:00 p.m. 3.1-19(b)		The facility has since had repairs made by the vendor to alleviate the faulty alarm. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The facility performs routine, scheduled maintenance, on a regular basis. Faulty alarms will be identified during said preventative maintenance, and repaired as needed. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The facility Maintenance Director performs weekly monitoring tests on the facility Generator and will hold responsibility to ensure all functions are properly working, and report needed repairs immediately to the vendor for repairs.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room where oxygen transferring takes place, was provided with properly working mechanical ventilation. NFPA 99 2012 edition, 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical exhaust to maintain a negative pressure in the space continuously. This deficient practice could affect up to 30 residents in one smoke	K 0927	K927 – Gas Equipment – Trans filling Cylinders **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** No residents identified. Facility Maintenance Director has replaced the ventilation fan found	04/30/2025

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	compartment. Findings include: Based on observations with the Maintenance Director on 03/31/25 at 2:18 p.m., the oxygen storage/transfer room contained large liquid oxygen tanks. There was a vent to the outside with a mechanically ventilated exhaust fan, but there was no pull of air from the vent. Based on interview at the time of observation, the Maintenance Director stated there was no pull of air, and the mechanically ventilated exhaust fan may not be working The findings were reviewed with the Maintenance Director during the exit conference at 3:00 p.m. 3.1-19(b)		to have been ineffective during survey. There is now a new ventilation fan in good working order in the Oxygen Fill room. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** The ventilation fan in the Oxygen Fill room has been replaced with a new fan. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Facility Maintenance Director will review the ventilation fan for proper functioning during daily preventative maintenance rounding, M-F. **How the corrective action will be monitored to ensure the deficient practice will not recur:** Facility Maintenance Director will monitor ventilation fan effectiveness during daily rounding, the facility Executive Director will monitor ventilation fan for proper functioning during daily rounds.	