| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15E683 | A. BUILDING -- B. WING | 04/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| MORGANTOWN WOODS OF JOURNEY | 140 W WASHINGTON ST MORGANTOWN, IN 46160 |

| (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 |
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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 04/29/25<br><br>Facility Number: 000399<br>Provider Number: 15E683<br>AIM Number: 100289100<br><br>At this Emergency Preparedness survey, Morgantown Woods of Journey was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.<br><br>The facility has 39 certified beds. At the time of the survey, the census was 34.<br><br>Quality Review completed on 05/02/25<br><br>The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by: | E 0000 | /p><br>/p><br>/p><br>/p><br>/p><br>/p> | |
| E 0039<br>SS=C<br>Bldg. -- | 403.748(d)(2), 416.54(d)(2), 418.113(d)(<br>EP Testing Requirements<br><br>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:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>a. When a community-based exercise is not | E 0039 | /p><br>/p><br>/p><br>/p><br>/p><br>/p><br>br><br>E039 | 05/29/2025 |

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

Phil Ford | Executive Director | 05/16/2025

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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| | accessible, conduct an annual individual, facility-based functional exercise.<br>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.<br>(ii) Conduct an additional exercise that may include, but is not limited to the following:<br>a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.<br>b. A mock disaster drill; or<br>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.<br>(iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review on 04/29/25 at 11:10 a.m. with the Maintenance Director, the facility could not provide documentation of; an annual full-scale exercise that is community-based, an annual individual, facility-based functional exercise, a second full-scale exercise that is community-based or an individual, facility-based functional exercise, a mock disaster drill, or a tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using | | **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:**<br>No specific residents were identified, but all facility residents would benefit from both a community-based emergency exercise and a facility-based emergency exercise. Both were scheduled but not yet completed. They will be completed by May 29, 2025.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.**<br>No specific residents were identified, but all facility residents would benefit from both a community-based emergency exercise and a facility-based emergency exercise. Both were scheduled but not yet completed. They will be completed by May 29, 2025.<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.**<br>A community-based emergency exercise and a facility-based exercise have been added to the TELs Master Schedule which will identify and continuously remind | |

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| | 15E683 | A. BUILDING -- B. WING | 04/29/2025 |

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| | a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. Based on an interview on 04/29/25 at 11:14 a.m., the Maintenance Director advised that he was unaware of the requirement to complete an annual full-scale exercise that is community-based, an annual individual, facility-based functional exercise, a second full-scale exercise that is community-based or an individual, facility-based functional exercise, a mock disaster drill, or 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. He then stated that he would discuss this matter with the facility Administrator and hold the drills as soon as possible.<br><br>This item was discussed with the facility Administrator and the Maintenance Director at the exit conference on 04/29/25. | | the Maintenance Director of their due dates. The Executive Director will also review the TELs Master Schedule to ensure completion. Education was provided to the Maintenance Director by the Executive Director on 5/12/25 concentrating on the importance of these required functions and their inclusion within the TELs Master Schedule.<br><br>**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 in place.**<br><br>On 5/15/2025, a QAPI meeting was held to review the Facility Plan of Correction which included the Administrator, Director of Nursing Services, Dietary Manager, Social Services/Activity Director, the Payroll/Benefits Clerk and the Maintenance Director.<br>A monthly audit of all Required and Scheduled Tasks as listed in TELs will be completed x 3 months by the Executive Director or the Maintenance Director.<br>These audits will be submitted to QAPI for review to decide if additional audits are warranted.<br>/p> | |

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| | 15E683 | A. BUILDING 01<br>B. WING | 04/29/2025 |

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| MORGANTOWN WOODS OF JOURNEY | 140 W WASHINGTON ST<br>MORGANTOWN, IN 46160 |

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| K 0000<br><br>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).<br><br>Survey Date: 04/29/25<br><br>Facility Number: 000399<br>Provider Number: 15E683<br>AIM Number: 100289100<br><br>At this Life Safety Code survey, Morgantown Woods of Journey was found not in compliance with Requirements for Participation in 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.<br><br>This one-story facility with a basement was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and all areas open to the corridor. The facility has battery-operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 39 and had a census of 34 at the time of this visit.<br><br>All areas where residents have customary access were sprinklered. The facility has one detached building providing storage services which was not sprinklered.<br><br>Quality Review completed on 05/02/25 | K 0000 | /p><br>/p><br>/p><br>/p><br>/p><br>/p> | |

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| MORGANTOWN WOODS OF JOURNEY | 140 W WASHINGTON ST<br>MORGANTOWN, IN 46160 |

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| K 0291 SS=F Bldg. 01 | NFPA 101<br>Emergency Lighting<br><br>Based on record review, interview, and observation, the facility failed to ensure 16 of 16 battery backup lights were tested monthly for 30 seconds and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff, and visitors in the facility.<br><br>Findings include:<br><br>Based on record review on 04/29/25 at 10:36 a.m. with the Maintenance Director, Battery- Operated emergency light testing documentation for the last twelve-month period for the facilities sixteen battery operated emergency lights could not be provided. Based on an interview on 04/29/25 at 10:38 a.m., the Maintenance Director indicated the facility has battery operated emergency exit lights throughout the facility, but since this testing was not in his TELS program, he was unaware of the testing requirements. Based on observations made during a tour of the facility with the Maintenance Director on 04/29/25 from 11:31 a.m. to 1:16 p.m., the facility had sixteen battery operated exit lights located at various locations. | K 0291 | K291<br><br>**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:**<br>No specific residents were identified, but all facility residents could be affected.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.**<br>No specific residents were identified, but all facility residents could be affected by not having properly operating emergency lighting. The annual testing of the emergency lighting was conducted by the Maintenance Director on 5/12/25 and found that all emergency lights were operating as they should.<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.**<br>The Monthly and Annual testing of the Emergency Lighting have been added to the TELs Master Schedule which will identify and continuously remind the | 05/29/2025 |

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| | This item was discussed with the facility Administrator and the Maintenance Director at the exit conference on 04/29/25.<br><br>3.1-19(b) | | Maintenance Director of their due dates. The Executive Director will also review the TELs Master Schedule to ensure completion. Education was provided to the Maintenance Director by the Executive Director on 5/12/25 concentrating on the importance of these required functions and their inclusion within the TELs Master Schedule.<br><br>**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 in place.**<br><br>On 5/15/2025, a QAPI meeting was held to review the Facility Plan of Correction which included the Administrator, Director of Nursing Services, Dietary Manager, Social Services/Activity Director, the Payroll/Benefits Clerk and the Maintenance Director.<br>A monthly audit of all Required and Scheduled Tasks as listed in TELs will be completed x 3 months by the Executive Director or the Maintenance Director.<br>These audits will be submitted to QAPI for review to decide if additional audits are warranted. | |
| K 0300 SS=F | NFPA 101<br>Protection - Other | | | |

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| Bldg. 01 | Based on record review, interview and observations, the facility failed to ensure documentation for the preventative maintenance of 20 of 20 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors.<br><br>Findings include:<br><br>Based on record review on 04/29/25 at 9:45 a.m. with the Maintenance Director, there was no itemized list of resident room battery operated smoke alarms testing for functionality on a monthly basis during the past twelve-month period available for review. Based on an interview on 04/29/25 at 9:47 a.m., the Maintenance Director acknowledged the battery-operated smoke detector manufacturer recommendations called for monthly testing as found in his "Life Safety" binder. Based on observations made on 04/29/25 between 11:31 p.m. and 1:16 p.m. during a tour of the facility with the Maintenance Director, battery operated smoke alarms were observed in all resident sleeping rooms.<br><br>This item was discussed with the facility Administrator and the Maintenance Director at the exit conference on 04/29/25. | K 0300 | K300<br><br>**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:**<br>No specific residents were identified, but all facility residents could be affected.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.**<br>No specific residents were identified, but all facility residents could be affected by not having properly operating battery operated smoke alarms. The monthly testing of the battery operated smoke alarms was conducted on 5/14/25 by the Maintenance Director and found that all battery operated smoke alarms were operating as they should.<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.**<br>The Monthly testing of the battery operated smoke alarms has been added to the TELs Master Schedule which will identify and continuously remind the | 05/29/2025 |

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| | 3.1-19(b) | | Maintenance Director of their due dates. The Executive Director will also review the TELs Master Schedule to ensure completion. Education was provided to the Maintenance Director by the Executive Director on 5/12/25 concentrating on the importance of these required functions and their inclusion within the TELs Master Schedule.<br><br>**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 in place.**<br><br>On 5/15/2025, a QAPI meeting was held to review the Facility Plan of Correction which included the Administrator, Director of Nursing Services, Dietary Manager, Social Services/Activity Director, the Payroll/Benefits Clerk and the Maintenance Director.<br>A monthly audit of all Required and Scheduled Tasks as listed in TELs will be completed x 3 months by the Executive Director or the Maintenance Director.<br>These audits will be submitted to QAPI for review to decide if additional audits are warranted. | |
| K 0324 SS=E | NFPA 101<br>Cooking Facilities | | | |

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| Bldg. 01 | Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed 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 could affect as many as 4 staff, in the facility.<br><br>Findings include:<br><br>Based on observations made during a tour of the facility with the Maintenance Director on 04/29/25 at 1:00 p.m., the four (4) burner stove and the flat grill which was located on the cooking line under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance | K 0324 | K324<br><br>**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:**<br>No specific residents were identified, but all facility residents could be affected.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.**<br>No specific residents were identified, but all facility residents could be affected by not providing an approved method for returning the four burner stove to an approved ~~design~~ designated location after it had been moved for maintenance and/or cleaning.<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.**<br>Wheel location will be designated on the kitchen floor using durable tape applied on 5/13/25 by the Maintenance Director at the approved design location beneath the kitchen hood extinguishing equipment to ensure proper placement of the four burner stove. The Dietary Manager will | 05/29/2025 |

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| | and/or cleaning. Based on interview on 04/29/25 at 1:04 p.m., the Maintenance Director stated that he was not aware an approved method should be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning and that he would have something done to the kitchen stove or floor to meet code compliance as soon as possible.<br><br>This item was discussed with the Maintenance Director and the facility Administrator at the exit conference on 04/29/25.<br><br>3.1-19(b) | | inspect the proper placement of the stove's wheels each morning during morning rounds using the durable tape as the guide for the approved design location.<br><br>**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 in place.**<br><br>On 5/15/2025, a QAPI meeting was held to review the Facility Plan of Correction which included the Administrator, Director of Nursing Services, Dietary Manager, Social Services/Activity Director, the Payroll/Benefits Clerk and the Maintenance Director.<br>A monthly audit of proper placement of the four burner stove using the durable tape as the guide will be completed x 3 months by the Executive Director or the Dietary Manager.<br>These audits will be submitted to QAPI for review to decide if additional audits are warranted. | |
| K 0345<br>SS=F<br>Bldg. 01 | NFPA 101<br>Fire Alarm System - Testing and Maintenance<br>1) Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code as required by LSC Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless | K 0345 | K345<br><br>**What corrective action will be accomplished for those** | 05/29/2025 |

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| | otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually:<br>a. Control unit trouble signals<br>b. Remote annunciators<br>c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.)<br>d. Notification appliances<br>e. Magnetic hold-open devices<br>This deficient practice could affect all building occupants.<br><br>Findings include:<br><br>During record review with the Maintenance Director on 04/29/25 at 9:35 a.m., documentation could not be provided regarding a visual semi-annual fire alarm system inspection. Based on interview on 04/29/25 at 9:37 a.m., the Maintenance Director agreed that a visual semi-annual inspection of the fire-alarm system had not been completed based on the fact that he had called his vendor and asked that all documentation for testing within the last year be sent to him and it was still not available for review as of the time of this survey with the last documented inspection of the fire alarm system being completed on 01/07/25 that was an anuual inspection. No other documentation could be provided.<br><br>This item was discussed with the Maintenance Director and the facility Administrator at the exit conference on 04/29/25.<br><br>3.1-19(b) | | **residents found to have been affected by the deficient practice:**<br>No specific residents were identified, but all facility residents could be affected.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.**<br>No specific residents were identified, but all facility residents could be affected by not having a properly operating fire alarm system. The semi-annual testing of the fire alarm system was conducted on 1/7/25 and found that the fire alarm system was operating as it should. Included on the Periodic Fire Alarm Inspection and Test report showing the 1/7/25 completion date identified above, in the lower section, point #11, is the date of the most recent Smoke Detector Sensitivity Test which was 7/14/23 – still in compliance (A copy of that inspection is also included with this packet)<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.**<br>The semi annual testing of the fire alarm system and the two year smoke detector sensitivity testing | |

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| | 15E683 | A. BUILDING 01<br>B. WING | 04/29/2025 |

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| MORGANTOWN WOODS OF JOURNEY | 140 W WASHINGTON ST<br>MORGANTOWN, IN 46160 |

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| | 2) Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, Section 14.4.5.3.1 states smoke detector sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states smoke detector sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with Section 14.4.5.3.3. This deficient practice could affect all occupants within the facility.<br><br>Findings include:<br><br>Based on record review with the Maintenance Director on 04/29/25 at 10:18 a.m., documentation could not be provided regarding a smoke detector sensitivity testing within the last two years. Based on interview on 04/29/25 at 10:20 a.m., the Maintenance Director agreed that a smoke detector sensitivity test of the facility smoke detectors had not been completed within the last two year period based on the fact that he had called his vendor and asked that all documentation for testing within the last two years be sent to him and it was still not available for review as of the time of this survey.<br><br>This item was discussed with the Maintenance Director and the facility Administrator at the exit conference on 04/29/25. | | have been added to the TELs Master Schedule by the Maintenance Director on 5/13/25 which will identify and continuously remind the Maintenance Director of their due dates. The Executive Director will also review the TELs Master Schedule to ensure completion. Education was provided to the Maintenance Director by the Executive Director on 5/12/25 concentrating on the importance of these required functions and their inclusion within the TELs Master Schedule.<br><br>**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 in place.**<br><br>On 5/15/2025, a QAPI meeting was held to review the Facility Plan of Correction which included the Administrator, Director of Nursing Services, Dietary Manager, Social Services/Activity Director, the Payroll/Benefits Clerk and the Maintenance Director.<br>A monthly audit of all Required and Scheduled Tasks as listed in TELs will be completed x 3 months by the Executive Director or the Maintenance Director.<br>These audits will be submitted to QAPI for review to | |

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| | 3.1-19(b) | | decide if additional audits are warranted. | |
| K 0353 SS=F Bldg. 01 | NFPA 101<br>Sprinkler System - Maintenance and Testing<br><br>Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 2 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility.<br><br>Findings include:<br><br>Based on record review of the quarterly sprinkler system inspection records on 04/29/25 at 9:50 a.m. | K 0353 | K353<br><br>**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:**<br>No specific residents were identified, but all facility residents could be affected.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.**<br>No specific residents were identified, but all facility residents could be affected by not having quarterly sprinkler system inspections. The first quarterly sprinkler system inspection was performed on 1/7/25 by Superior Systems. The second quarterly inspection of the sprinkler system will be conducted on 5/19/25 by Superior Systems.<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** | 05/29/2025 |

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| | with the Maintenance Director, there were no quarterly sprinkler system inspection reports available for the third quarter (July, August, and September) or the fourth quarter (October, November, and December) of 2024. Based on an interview on 04/29/25 at 9:54 a.m., the Maintenance Director acknowledged there was no written documentation available to show the sprinkler system had been inspected during the third or fourth quarters of 2024 based on the fact that he had called his vendor and asked that all documentation for testing within the last year be sent to him and it was still not available for review as of the time of this survey.<br><br>This item was discussed with the Maintenance Director and the facility Administrator at the exit conference on 04/29/25.<br><br>3.1-19(b) | | The quarterly inspection of the sprinkler system has been added to the TELs Master Schedule which will identify and continuously remind the Maintenance Director of their due dates. The Executive Director will also review the TELs Master Schedule to ensure completion. Education was provided to the Maintenance Director by the Executive Director on 5/12/25 concentrating on the importance of these required functions and their inclusion within the TELs Master Schedule.<br><br>**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 in place.**<br><br>On 5/15/2025, a QAPI meeting was held to review the Facility Plan of Correction which included the Administrator, Director of Nursing Services, Dietary Manager, Social Services/Activity Director, the Payroll/Benefits Clerk and the Maintenance Director.<br>A monthly audit of all Required and Scheduled Tasks as listed in TELs will be completed x 3 months by the Executive Director or the Maintenance Director.<br>These audits will be submitted to QAPI for review to | |

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| | | | decide if additional audits are warranted. | |
| K 0712<br>SS=F<br>Bldg. 01 | NFPA 101<br>Fire Drills<br><br>1) Based on record review and interview, the facility failed to ensure 6 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors.<br><br>Findings include:<br><br>Based on record review of the document titled "Direct Supply - TELS (Conduct a fire drill) with the Maintenance Director on 04/29/25 at 9:12 a.m., the documentation for the fire drills for six of the past twelve months lacked verification of the transmission of the signal to the monitoring company for the drills. Based on an interview on 04/29/25 at 9:14 a.m., the Maintenance Director stated that he was unaware of the need for verification of the transmission of the signal for drills with the monitoring company stating that he was not told of this requirement during his limited training at this facility.<br><br>This item was discussed with the Maintenance Director and the facility Administrator at the exit conference on 04/29/25.<br><br>3.1-19(b)<br>3.1-51(c) | K 0712 | K712<br><br>**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:**<br>No specific residents were identified, but all facility residents could be affected.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.**<br>No specific residents were identified, but all facility residents could be affected by not having properly scheduled fire drills that include verification of the transmission of the signal to the monitoring company for the drills.<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.**<br>Properly scheduled fire drills that include verification of the transmission of the signal to the monitoring company for the drills have been added to the TELs | 05/29/2025 |

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| | 2) Based on record review and interview, the facility failed to conduct quarterly fire drills for 2 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents.<br><br>Findings include:<br><br>Based on record review of the document titled "Direct Supply - TELS (Conduct a fire drill) with the Maintenance Director on 04/29/25 at 9:15 a.m., there was no documentation for a first quarter (January, February, and March) of 2025 fire drill being conducted on the first or second shifts of 2025. Furthermore, there was no documentation for a fire drill being conducted in the fourth quarter (October, November, and December) of 2024 on the third shift. Based on an interview on 04/29/25 at 9:17 a.m., the Maintenance Director acknowledged the aforementioned missing fire drills stating that no further documentation could be located for fire drills as of the time of this survey.<br><br>This item was discussed with the Maintenance Director and the facility Administrator at the exit conference on 04/29/25.<br><br>3.1-19(b)<br>3.1-51(c) | | Master Schedule which will identify and continuously remind the Maintenance Director of their due dates. The Executive Director will also review the TELs Master Schedule to ensure completion. Education was provided to the Maintenance Director by the Executive Director on 5/12/25 concentrating on the importance of these required functions and their inclusion within the TELs Master Schedule. (Completed 3rd shift Fire Drill for the 4th quarter on 2024 was found in the Life Safety binder. Additionally, all three of the first quarter of 2025 Fire Drills were also found in a second file, completed for all shifts. All 4 of these documents have been uploaded.)<br><br>**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 in place.**<br><br>On 5/15/2025, a QAPI meeting was held to review the Facility Plan of Correction which included the Administrator, Director of Nursing Services, Dietary Manager, Social Services/Activity Director, the Payroll/Benefits Clerk and the Maintenance Director.<br>A monthly audit of all Required and Scheduled Tasks as listed in TELs will be completed x | |

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| | | | 3 months by the Executive Director or the Maintenance Director.<br>These audits will be submitted to QAPI for review to decide if additional audits are warranted. | |
| K 0921 SS=F Bldg. 01 | NFPA 101<br>Electrical Equipment - Testing and Maintenanc<br>Based on record review, observation, and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances | K 0921 | K921<br><br>**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:**<br>No specific residents were identified, but all facility residents could be affected.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.**<br>No specific residents were identified, but all facility residents could be affected by not having properly scheduled a (PCREE) Patient Care Related Electrical Equipment inspection and documentation for those related devices put into service and after any repair or modification of those related devices.<br><br>**What measures will be put into place and what systemic** | 05/29/2025 |

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| | receive continuous training. This deficient practice could affect all residents.<br><br>Findings include:<br><br>Based on record review on 04/29/25 at 10:46 a.m. with the Maintenance Director, there was no documentation for the testing of Patient Care Related Electrical Equipment (PCREE), such as electric beds, nebulizers, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment. Based on interview at 10:48 a.m., the Maintenance Director stated that he was unaware of the regulations to conduct PCREE testing and would find a way to have it completed as soon as possible. Based on observations made between 11:31 a.m. and 1:16 p.m. during a tour of the facility with the Maintenance Director, it was revealed the facility provided PCREE such as electric beds, air pumps for air mattresses, and other electrical medical equipment was present in the facility.<br><br>This item was discussed with the Maintenance Director and the facility Administrator at the exit conference on 04/29/25.<br><br>3.1-19(b) | | **changes will be made to ensure that the deficient practice does not recur.**<br>A properly scheduled (PCREE) Patient Care Related Electrical Equipment inspection including the documentation for those related devices put into service or after any repair or modification of those related devices will be completed by 5/15/25 and has been added to the TELs Master Schedule by the Maintenance Director on 5/13/25 which will identify and continuously remind the Maintenance Director of their due dates. The Executive Director will also review the TELs Master Schedule to ensure completion. Education was provided to the Maintenance Director by the Executive Director on 5/12/25 concentrating on the importance of these required functions and their inclusion within the TELs Master Schedule.<br><br>**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 in place.**<br><br>On 5/15/2025, a QAPI meeting was held to review the Facility Plan of Correction which included the Administrator, Director of Nursing Services, Dietary Manager, Social Services/Activity Director, the | |

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| | | | Payroll/Benefits Clerk and the Maintenance Director.<br>A monthly audit of all Required and Scheduled Tasks as listed in TELs will be completed x 3 months by the Executive Director or the Maintenance Director.<br>These audits will be submitted to QAPI for review to decide if additional audits are warranted. | |
| K 0923 SS=E Bldg. 01 | NFPA 101<br>Gas Equipment - Cylinder and Container Storag<br>Based on observation and interview, the facility failed to ensure 1 of 1 storage locations of nonflammable gases equal to or greater than 3000 cubic feet were secured against unauthorized entry. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2.1 states storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. This deficient practice could affect 25 staff and visitors in the vicinity of the oxygen storage and transfilling room.<br><br>Findings include:<br><br>Based on observations made with Maintenance Director during a tour of the facility on 04/29/25 at 11:45 a.m., the corridor entry door to the oxygen storage and transfilling room was equipped with a lock or means to secure against unauthorized entry, but the door did not fully close and latch into the doorframe when tested on three separate occasions. The room contained six liquid oxygen | K 0923 | K923<br><br>**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:**<br>No specific residents were identified, but all facility residents could be affected.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.**<br>No specific residents were identified, but all facility residents could be affected by not having a properly door that will fully latch into the door frame.<br><br>**What measures will be put into place and what systemic** | 05/29/2025 |

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| | containers and ten 'E' type cylinders. Based on interview on 04/29/25 at 11:47 a.m., the Maintenance Director stated that he was unaware of the regulation regarding separation of the oxygen transfilling room by a 1-hour barrier or the need for the corridor door to fully close and latch into the doorframe adding that he would have the door serviced or repaired as soon as possible.<br><br>This item was discussed with the Maintenance Director and the facility Administrator at the exit conference on 04/29/25.<br><br>3.1-19(b) | | **changes will be made to ensure that the deficient practice does not recur.**<br>The door latch/frame was assessed by the Maintenance Director who determined the need for a new door latch. The new door latch (knob-handle) was installed on 5/12/25. The door/latch was tested ten separate times by the Maintenance Director and fully closed each of those times.<br><br>**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 in place.**<br><br>On 5/15/2025, a QAPI meeting was held to review the Facility Plan of Correction which included the Administrator, Director of Nursing Services, Dietary Manager, Social Services/Activity Director, the Payroll/Benefits Clerk and the Maintenance Director.<br>A monthly audit of proper placement of the functioning of this door latch will be completed x 3 months by the Executive Director or the Maintenance Director.<br>These audits will be submitted to QAPI for review to decide if additional audits are warranted. | |

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