STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155582	A. BUILDING -- B. WING	04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE	300 N WASHINGTON ST WAKARUSA, IN 46573

(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: 04/21/2025 Facility Number: 000521 Provider Number: 155582 AIM Number: 100266980 At this Emergency Preparedness survey, The Waters of Wakarusa Skilled Nursing Facility was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 133 certified beds. 109 are dually certified for Medicare and Medicaid; 24 are certified for Medicare only. At the time of the survey, the census was 77. Quality Review completed on 04/23/25	E 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
E 0018 SS=F Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(Procedures for Tracking of Staff and Patients Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures included a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b) (2). This	E 0018	**E018 –** It is the intent of the facility to ensure emergency preparedness policies and procedures include a system to track the location of on duty staff and sheltered residents in the LTC facility's care during and after an emergency to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**:	05/23/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
David Henke	HFA	05/05/2025

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	155582	A. BUILDING -- B. WING	04/21/2025

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	deficient practice could affect all residents and staff. Findings include: Based on record review with the Administrator and Maintenance Director at 11:41 a.m. on 04/21/25, no policies or procedures that included a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency was available for review. Based on interview with the Administrator at 11:31 a.m. on 04/21/25, he acknowledged no policy or procedure for tracking of residents or staff was available. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.		a On 04/28/2025, the Maintenance Supervisor/DON/Administrator reviewed and updated the policies and procedures in the emergency plan to include policies and procedures that include a system to track the location of on duty staff and sheltered residents in the LTC facility's care during and after an emergency to meet set standards. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 04/28/2025, he Administrator in serviced the DON/ Maintenance Supervisor to ensure to update the policy and procedures annually to include a system to track the location of on duty staff and sheltered residents in the LTC facility's care during and after an emergency to meet set standards. The Administrator inserviced all staff on the updated emergency preparedness program on 04/28/2025. b The Administrator/Maintenance Supervisor/designee will ensure to review and update the policies and procedures in the emergency plans annually to include a system to track the location of on duty staff and sheltered residents	

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			in the LTC facility's care during and after an emergency to meet set standards. Adelia communication system initiated on 04/28/2025, corporate training on 04/27/2025. c The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The Administrator and Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual to ensure it includes a letter from their natural gas provider to meet set standards. Those reviews will be documented as appropriate. The Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. Results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. Paper Compliance is requested secondary to no harm or incident.	
E 0031 SS=F Bldg. --	403.748(c)(2), 416.54(c)(2), 418.113(c)(Emergency Officials Contact Information Based on record review and interview, the facility failed to ensure the emergency preparedness	E 0031	**E031** – It is the intent of the facility to ensure the emergency	05/23/2025

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	communication plan includes (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff (ii) The State Licensing and Certification Agency (iii) The Office of the State Long-Term Care Ombudsman (iv) Other sources of assistance in accordance with 42 CFR 483.475(c)(2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Administrator and Maintenance Director at 11:31 a.m. on 04/21/25, the facility failed to include contact information which included the IDOH gateway website or incidents email as the primary and alternate means of contacting IDOH in the communication section of the emergency preparedness (EP) manual. Based on interview with the Administrator at 11:31 a.m. on 04/21/25, he acknowledged the information was not included in the EP. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.		preparedness communication plan includes contact information for the following: federal, State, tribal, regional or local emergency preparedness staff, the state licensing and certification agency, the office of the state long term care ombudsman, other sources of assistance in accordance with 42 CFR 483.73©(2) to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 04/28/2025, the Administrator and the Maintenance Supervisor/designee reviewed and updated the emergency preparedness communication plan to include contact information which includes the IDOH gateway website or incidents email as the primary and alternate means of contacting IDOH in the communication section of the emergency preparedness manual to meet set standards. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 04/28/2025 the Administrator inserviced the DON/Maintenance Supervisor/all staff on the requirement to ensure to review and update the emergency preparedness policies	

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			annually and to include the IDOH gateway website or incidents email as the primary and alternate means of contacting IDOH in the communication section of the emergency preparedness manual to meet set standards. b DON/Maintenance Supervisor/designee will work with the Administrator to ensure to review and update the emergency preparedness communication plan annually and to include the IDOH gateway website or incidents email as the primary and alternate means of contacting IDOH in the communication section of the emergency preparedness manual to meet set standards. If any issues are discovered, they will be addressed and resolved immediately. The Administrator attend the County wide Emergency Drill on 04/23/2025 and inserviced the staff and managers on 04/28/2025. c The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a At least annually to ensure compliance, the Administrator and DON/Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual and conduct required exercises and make changes as	

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			necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. Results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. Paper compliance is requested secondary to no harm or incident.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based	E 0039	**E039** – It is the intent of the facility to ensure to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On 04/28/2025, the Administrator and the DON/Maintenance Supervisor/designee conducted a full-scale community based exercise, a facility based functional exercise or an actual natural or man-made emergency that requires activation of the emergency plan and documented the information on the after-action report and in the Life Safety Binder	05/23/2025

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	functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Administrator and Maintenance Director at 12:10 p.m. on 04/21/25, the facility failed to provide documentation of a full-scale community-based exercise, a facility-based functional exercise or an actual natural or man-made emergency that required activation of the emergency plan. Based on interview with the Administrator at 12:10 p.m. on 04/21/25, the Administrator stated, a full-scale community-based exercise, a facility-based functional exercise or an actual natural or man-made emergency that required activation of the emergency plan was not conducted during the time he was the facility administrator, and he was not aware of any conducted in the last 12-month period. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.		to meet set standards. **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 04/28/2025the Administrator in serviced the DON/ Maintenance Supervisor/designee on the requirement to conduct annual exercises to include a full scale community based exercise, a facility based functional exercise or an actual natural or man-made emergency that requires activation of the emergency plan and document on the after-action report and in the Life Safety Binder to meet set standards. b DON/Maintenance Supervisor/designee will work with the Administrator to ensure to conduct annual exercises to include a full scale community based exercise, a facility based functional exercise or an actual natural or man-made emergency that requires activation of the emergency plan and document on the after-action report and in the Life Safety Binder to meet set standards. If any issues are discovered, they will be addressed and resolved immediately. The Administrator attended a full scale drill with the Elkhart County Emergency Management Department on 04/23/2025.	

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			Certificate attached. The staff were inserviced on the drill on 04/28/2025. c The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a At least annually to ensure compliance, the Administrator and DON/Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual and conduct required exercises and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. Results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. Paper Compliance is requested secondary to no harm or incident.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review, observation, and interview; the facility failed to document 36-month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA	E 0041	**E041**– It is the intent of the facility to ensure to document 36-month period emergency generator testing for emergency generators	05/23/2025

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	99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Administrator and Maintenance Director at 10:44 a.m. on 04/21/25, documentation was not available to show a 36-month period load est for 4 continuous hours for the diesel emergency generator. Based on interview at the time of record review, the Maintenance Director stated the generator service vendor had performed maintenance on the generator in December and believed the test had been conducted at that time; however, documentation of a generator load test from the generator service vendor dated 12/11/2024, indicated the test was for a load bank test and was tested for 1.8 hours. Based on interview with the Administrator and Maintenance Director at 10:44 a.m. on 04/21/25, no other documentation indicating a 4-hour load test within 36 months had		in accordance with NFPA 99 and NFPA 110 to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On 05/23/2025, the certified Generator Contractor/Maintenance Supervisor/designee will conduct the four-hour load bank testing on the facility's emergency generator and documented the results in the Life Safety Binder to meet set standards. The Administrator will verify the work on that same day. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 5/23/2025, the Administrator inserviced the Maintenance Supervisor/ designee on the requirement to ensure to conduct the four-hour load bank testing on the facility's emergency generator and document the results in the Life Safety Binder to meet set standards. b The Maintenance Supervisor/designee will ensure to conduct the four-hour load bank testing on the facility's emergency generator and document the results in the Life Safety Binder as a part of the facility's annual Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be	

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	been completed was available. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.		addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. **4.MONITORING CORRECTIVE ACTION**: a. At least every month the load bank testing will be completed and weekly inspection of the generator will be conducted to ensure compliance; the Administrator and Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. Results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. Paper compliance is requested secondary to no harm or incident.	
K 0000 Bldg. 01				

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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: 04/21/2025 Facility Number: 000521 Provider Number: 155582 AIM Number: 100266980 At this Life Safety Code survey, The Waters of Wakarusa Skilled Nursing Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 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. 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 and in areas open to the corridors. 73 resident rooms were provided with battery operated smoke detectors. The facility is partially protected by a diesel-powered 230 kW emergency generator. The facility has 133 certified beds. 109 are dually certified for Medicare and Medicaid; 24 are certified for Medicare only. At the time of the survey, the census was 77. Quality Review completed on 04/23/25	K 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to maintain 1 of 1 kitchen extinguishing	K 0324	**K324**– It is the intent of the facility to ensure to maintain kitchen	05/23/2025

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	system in accordance with NFPA 96, Standard for Ventilation and Fire Protection of Commercial Cooking Operations, Section 10.5.1 states A readily accessible means for manual activation shall be located between 42 in. and 48 in. above the floor, be accessible in the event of a fire, be located in a path of egress, and clearly identify the hazard protected. Additionally, NFPA 101, Life Safety Code, 4.6.12.3 states that existing life safety features obvious to the public, if not required by the code, shall be either maintained or removed. This deficient practice could affect kitchen staff only. Findings include: Based on observation with the Maintenance Director at 12:43 p.m. on 04/21/2025, the ANSUL "Pull Station" was mounted 57 inches above the floor on the wall in the path of egress of the kitchen. Based on interview at 12:43 p.m., the Maintenance Director acknowledged the measurement as measured with a tape measure. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		extinguishing system in accordance with NFPA 96, Standard for ventilation and fire protection of commercial cooking operations to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. Will complete on 5/23/2025, the facilities licensed fire alarm contractor will relocate the Ansul Pull Station in the kitchen to meet set standards. The Administrator will verify the work on the same day . **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. **3. MEASURES TO PREVENT REOCCURRENCE**: a. The Administrator in serviced the Maintenance Supervisor/all dietary staff/designee to ensure to maintain kitchen extinguishing system including the ansul pull station in the kitchen to meet set standards on 3/23/2025. b. The Maintenance Supervisor and Dietary Manager will ensure to maintain kitchen extinguishing system including the ansul pull station in the kitchen as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee	

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(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
			will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The monitoring results will be presented by the Administrator at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. Paper compliance is requested as no harm or incident was noted.	
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Based on record review and interview, the facility failed to provide a complete written policy in the event the fire alarm system has to be placed out-of-service for 4 hours or more in a 24-hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review with the Administrator and Maintenance Director at 11:29 a.m. on	K 0346	**K346**– It is the intent of the facility to ensure to provide a complete written policy in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.6 to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 04/28/2025, the Administrator/Maintenance	05/23/2025

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	155582	A. BUILDING 01 B. WING	04/21/2025

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	04/21/25, the fire watch plan failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.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@isdh.in.gov. Based on interview with the Administrator and Maintenance Director at 11:29 a.m. on 04/21/25, the Administrator acknowledged the fire watch plan did not include contact information for IDOH. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		Supervisor updated the fire watch plan to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting Form and emailing it to incidents@isdh.in.gov to meet set standards. The Administrator verified the work on 04/28/2025 . 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 04/28/2025, the Administrator in serviced the Maintenance Supervisor/DON/All staff on the requirement to ensure the fire watch plan is fully updated to meet set standards. b Maintenance Supervisor/DON/designee will ensure the fire watch plan is fully updated as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results.	

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			c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. Paper Compliance is requested secondary to no harm or incident recorded.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on record review, the facility failed to maintain 1 of 1 wet sprinkler system in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.3.4. Section 5.3.4 states that the freezing point of solutions in antifreeze shall be tested annually by measuring the specific gravity with a hydrometer or refractometer and adjusting the solution if necessary. This deficient practice could affect all	K 0353	**K353** – It is the intent of the facility to ensure to maintain the wet sprinkler systems in accordance with NFPA 25, Standard for the inspection, testing and maintenance of water based fire protection systems, section 5.3.4 and to ensure automatic sprinkler piping systems are examined for internal	05/23/2025

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	residents, staff and visitors. Findings include: Based on record review and interview with the Administrator and Maintenance Director at 9:37 a.m. on 04/21/25, page 2 of 4 of the sprinkler inspection dated 03/05/2025 from the sprinkler vendor, indicated that the antifreeze solution system was tested and left in satisfactory condition; however, the document did not include the freezing point. In accordance with NFPA 25 Figure A.5.3.4.1 the solution should be adjusted to -10 degrees Fahrenheit. Based on interview at 9:37 a.m. on 04/21/25, the Maintenance Director was not aware they had an antifreeze sprinkler system and discussed the antifreeze solution of the generator. 2. Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, Section 14.2.1. Section 14.2.1 states, "except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review with the Administrator		obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011 edition, the standards for the inspection testing and maintenance of water based fire protection system, section 14.2.1 to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 05/23/2025, the licensed sprinkler contractor resubmitted their paperwork showing the proper freeze point to meet set standards. The Administrator verified the work on 05/05/2025. 2.On 04/25/2025, the Licensed Sprinkler Contractor/Maintenance Supervisor conducted the internal pipe inspection of the wet pipe system and documented the results in the facilities Life Safety Binder to meet set standards. The Administrator verified the work on 04/25/2025. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 04/28/2025, the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure to maintain the sprinkler system per the requirements of NFPA 25 and	

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	and Maintenance Director at 10:15 a.m. on 04/21/2025, no documentation of an internal pipe inspection of the wet pipe system located in the facility was available for review. Based on interview with the Administrator and Maintenance Director at 10:15 a.m. on 04/21/2025, the Administrator advised the Maintenance Director to contact the sprinkler vendor immediately and request documentation of the last internal pipe inspection. Based on record review and interview with the Administrator and Maintenance Director at 11:55 a.m. on 04/21/2025, the Maintenance Director provided documentation titled: "SPRINKLER: FIVE YEAR INTERNAL PIPE INSPECTION" that was dated 06/18/2019. The Maintenance Director also provided a document dated 04/21/2025 from the sprinkler vendor stating they scheduled a five year internal pipe inspection to be conducted on 04/25/2025. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		to ensure to conduct all inspections and document the results in the facilities Life Safety Binder to meet set standards. 2.Maintenance Supervisor/designee will ensure to maintain the sprinkler system per the requirements of NFPA 25 and to ensure to conduct all inspections and document the results in the facilities Life Safety Binder as a part of the facility's Annual Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with	

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			subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. Paper compliance is requested secondary to no harm or incident recorded.	
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Based on record review and interview, the facility failed to provide a complete written policy 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 residents, staff and visitors. Findings include: Based on record review with the Administrator and Maintenance Director at 11:29 a.m. on 04/21/25, the fire watch plan failed to include	K 0354	**K354**– It is the intent of the facility to ensure to provide correct written policies 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 to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On 04/28/2025, the Administrator/Maintenance Supervisor updated the fire watch plan to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting Form and emailing it to incidents@isdh.in.gov to meet set standards. The Administrator verified the work on 04/28/2025. **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and	05/23/2025

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	contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.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@isdh.in.gov. Based on interview with the Administrator and Maintenance Director at 11:29 a.m. on 04/21/25, the Administrator acknowledged the fire watch plan did not include contact information for IDOH. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		visitors have the potential to be affected but none were. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 04/28/2025, the Administrator in serviced the Maintenance Supervisor/All staff on the requirement to ensure the fire watch plan is updated to meet set standards. b Maintenance Supervisor/designee will ensure the fire watch plan is updated as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system	

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			components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. Paper compliance is requested secondary to no harm or incident reported.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 2 electrical receptacles within 6 feet of the outside edge of 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 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 Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting,	K 0511	**K511**– It is the intent of the facility to ensure electrical receptacles within six feet of the outside edge of a sink are provided with ground fault interrupter (GFCI) protection against electric shock to meet set standards. 1 **CORRECTIVE ACTIONS TAKE** 2 **On** 04/25/2025, the Maintenance Supervisor/licensed electrician installed a GFCI receptacle in the main dining room to meet set standards. The Administrator verified the work on 04/26/2025. a On 04/25/2025, the Maintenance Supervisor/licensed electrician installed a GFCI receptacle in the Rehab Hall to meet set standards. The Administrator verified the work on 04/26/2025. 3 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be	05/23/2025

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	deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used. This deficient practice had the potential to affect residents, staff, and visitors in 2 of 7 smoke compartments. Findings include: 1.) Based on observation with the Maintenance Director at 12:34 p.m. on 04/21/25, one electrical		affected but none were. Maintenance Supervisor checked all other areas and found no other negative findings. 4 **MEASURES TO PREVENT REOCCURRENCE**: a On 04/28/2025, the Administrator inserviced the Maintenance Supervisor/designee on the requirement to ensure the receptacle outlets have grounding protection in all resident areas to meet set standards. b Maintenance Supervisor/designee will ensure the receptacle outlets have grounding protection in all resident areas as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 5 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the	

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	receptacle 5 feet from the edge of the sink in the main dining room was not GFCI protected when tested. The electrical receptacle was a standard type and when tested, failed to interrupt service. Based on interview with the Maintenance Director at 12:34 p.m. on 04/21/25, he acknowledged the electrical service was not interrupted when tested with a GFCI tester. 2.) Based on observation with the Maintenance Assistant at 1:34 p.m. on 04/21/25, one electrical receptacle 2 feet from the edge of the sink in the Rehab Hall was not GFCI protected when tested. The electrical receptacle was a standard type and when tested, failed to interrupt service. Based on interview with the Maintenance Assistant at 1:34 p.m. on 04/21/25, he acknowledged the electrical service was not interrupted when tested with a GFCI tester. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. Paper compliance requested secondary to no harm or incident occurred.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview the facility failed to conduct fire drills in accordance with the requirements of NFPA 101 - 2012 edition, Sections 4.7.1, 4.7.2, 4.7.6, 19.7.1, 19.7.1.2, 19.7.1.4 and 19.7.1.6. This deficient practice had the potential to affect all residents, staff, and visitors. Findings include: 1. Based on record review with the Administrator and Maintenance Director at 9:37 a.m. on 04/21/25, documentation for a first shift fire drill during the	K 0712	**K712** –It is the intent of the facility to ensure to conduct fire drills in accordance with the requirements of NFPA 101- 2012 edition to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 05/05/2025, the Maintenance Supervisor conducted a fire drill on all three shifts at varying times and documented the results on the	05/23/2025

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	fourth quarter of 2024 was not available for review. Documentation of a fire drill dated 10/07/2024 indicated a fire drill was conducted at 2:45 p.m., this document also stated it was for a first shift; however, based on interview with the Maintenance Director and Administrator the first shift hours are 6:00 a.m. to 2:00 p.m. and the time of this drill would have been during the second shift. 2. Based on record review with the Administrator and Maintenance Director at 9:42 a.m. on 04/21/2025, documentation for a third shift fire drill conducted during the second quarter of 2024 was incomplete. Documentation of a fire drill dated 06/06/2024 indicated a fire drill was conducted at 1:15 a.m.; however, there was no indication of who participated in the drill. 3. Based on record review with the Administrator and Maintenance Director at 9:43 a.m. on 04/21/2025, documentation for a second shift fire drill conducted during the second quarter of 2024 was incomplete. Documentation of a fire drill dated 05/07/2024 indicated a fire drill was conducted at 7:15 p.m.; however, there was no indication of who participated in the drill or if the alarm signal was received by the monitoring company. Based on interview at 9:43 a.m. on 04/21/2025, the Administrator asked the Maintenance Director if he had any documentation of the participants. The Maintenance Director was not able to provide any documentation of the participants. Based on interview at 9:43 a.m. on 04/21/2025, the Administrator and the Maintenance Director stated they were not working at the facility during the second quarter of 2024 and could not provide information about the missing information.		after-action report in the facilities Life Safety Binder to meet set standards. The Administrator will verify the work on 05/05/2025. b On 05/06/2025, the Maintenance Supervisor will conduct a fire drill on all three shifts at varying times with a roster of attendees who participated to meet set standards. The Administrator will verify the work on 05/07/2025 . c On 05/07/2025, the Maintenance Supervisor will conduct a fire drill on all three shifts at varying times with a roster of attendees who participated and confirmed the alarm signal was received by the monitoring company to meet set standards. The Administrator will verify the work on 05/08/2025. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 04/28/2028, the Administrator inserviced the Maintenance Supervisor on the requirement to ensure fire drills are conducted at the correct time, on varying shifts and include a roster of attendees and activation of the fire alarm system and transmission of the fire alarm signal to meet set standards. b Maintenance	

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(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
	This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b) 3.1-51(c)		Supervisor/Administrator/designee will ensure fire drills are conducted at the correct time, on varying shifts and include a roster of attendees and activation of the fire alarm system and transmission of the fire alarm signal as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The fire drill documentation will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. Paper compliance is requested	

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	155582	A. BUILDING 01 B. WING	04/21/2025

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			secondary to no harm or incident occurred.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on record review, observation and interview, the facility failed to provide ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design in 1 of 1 outdoor areas where smoking occurred. This deficient practice could affect staff outside of the facility near the storage building. Findings include: Based on record review with the Administrator and Maintenance Director at approximately 9:30 a.m. on 04/21/25, the facility provided a copy of the facility's smoking policy that indicated that smoking on the facility property was prohibited. Based on observation with the Maintenance Assistant at 2:04 p.m. on 04/21/2025, a cigarette butt tower was provided next to a bench located near the storage building outside the rear of the facility; however, more than 27 cigarette butts were strewn on the ground around the area of the bench. Based on interview with the Maintenance Assistant he acknowledged there were more than 27 cigarette butts strewn on the ground. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)	K 0741	**K741** – It is the intent of the facility to ensure to provide ashtrays and metal containers with self closing cover devices into which ashtrays can be emptied of noncombustible material and safe design in outdoor areas where smoking occurs to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 04/27/2025, the Housekeeping Supervisor/ Maintenance Supervisor/Administrator cleaned up the public way behind the shed to meet set standards. The Administrator verified the work on 04/27/2025 . 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 05/05/2025, the Administrator inserviced all staff on the facilities smoking policy to meet set standards. b Maintenance Supervisor/Administrator/DON/Housekeeping Supervisor/designee will conduct weekly inspections on	05/23/2025

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			the property of the public way behind the maintenance shed as a part of the facilities weekly as a part of the Smoking Policy. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Smoking Policy and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. Paper compliance is requested secondary to no harm or incident was reported.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review, observation, and	K 0918	**K918** - It is the intent of the facility	05/23/2025

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	interview; the facility failed to document 36-month emergency generator load testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Administrator and Maintenance Director at 10:44 a.m. on 04/21/25, documentation was not available to show a 36-month period load test for 4 continuous hours for the diesel emergency generator. Based on interview at the time of record review, the Maintenance Director stated the generator service vendor had performed maintenance on the generator in December and believed the test had been conducted at that time; however, documentation of a generator load test from the generator service vendor dated 12/11/2024, indicated the test was for a load bank test and was tested for 1.8 hours. Based on interview with the		to ensure to document 36-month generator load testing for emergency generators in accordance with NFPA 99 and NFPA 110 to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: A On 05/19/2025, the Maintenance Supervisor/the facilities certified generator contractor will conduct the thirty-six-month period emergency generator load testing for four hours and documented the results in the Life Safety Binder to meet set standards. The Administrator will verify the work on 05/19/2025. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: 1.On 04/28/2025, the Administrator inserviced the Maintenance Supervisor/designee on the requirement to ensure to conduct proper maintenance and testing of the emergency generator including conducting the thirty-six-month load testing for four hours to meet set standards. b The Maintenance Supervisor will ensure to conduct proper maintenance and testing of the emergency generator including conducting the thirty-six-month load testing for four hours to as a part of the facility's Preventive	

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	Administrator and Maintenance Director at 10:44 a.m. on 04/21/25, no other documentation indicating a 4-hour test within 36 months had been completed. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure flexible cords were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical	K 0920	**K920** – It is the intent of the facility to ensure flexible cords are not used as a substitute for fixed wiring to meet set standards. **1.CORRECTIVE ACTIONS**	05/23/2025

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	Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff in the social services office. Findings include: Based on observation with the Maintenance Director at 12:25 p.m. on 04/21/2025, Christmas type lights were powered by a power strip that was plugged into a second power strip that was plugged into a third power strip that was plugged into a wall receptacle. Based on interview with the Maintenance Director at 12:25 p.m. on 04/21/25, he acknowledged the multiple power strips plugged into each other. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		**TAKEN**: 1.On 04/21/2025, the Maintenance Supervisor/designee removed the three powers strips to meet set standards. The Administrator verified the removal on 04/21/2025 . **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. On 04/21/2025 the Maintenance Supervisor/designee inspected all rooms throughout the facility for power strips and found no other negative findings. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On the Administrator inserviced the Maintenance Supervisor/designee/all other staff that power strips are not to be used as a substitute for fixed wiring to meet set standards. 2.Maintenance Supervisor/designee will inspect all rooms throughout the facility monthly to ensure they do not have power strips in use as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will	

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			monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. Paper compliance is requested secondary to no harm or incident was reported.	
K 0927 SS=F Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders 1.) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfilling rooms was provided with properly working mechanical ventilation. NFPA 99, Health Care Facilities, 2012 edition, Section 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 all residents, staff and visitors.	K 0927	**K927**– It is the intent of the facility to ensure oxygen storage/transfilling rooms are provided with properly working mechanical ventilation and to ensure make up air is provided in oxygen storage rooms where oxygen transfilling takes place and to ensure oxygen cylinders are segregated by full and empty and are marked to avoid confusion to	05/23/2025

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	Findings include: Based on observation with the Maintenance Director at 1:06 p.m. on 04/21/2025, there was an exhaust fan in the wall near the ceiling of the oxygen storage/transfilling room; however, it was not providing a negative pressure at the time of observation. The exhaust fan was making a loud mechanical noise but was not providing a negative air pressure. Based on interview with the Maintenance Director at 1:06 p.m. on 04/21/2025, he acknowledged the oxygen storage/transfilling room did not have a fresh air supply and that the mechanical exhaust fan was not providing a negative pressure. 2.) Based on observation and interview, the facility failed to ensure make-up air was provided in 1 of 1 oxygen storage rooms where oxygen transfilling takes place. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 9.3.7.5.3.7 states a means of make-up air shall be provided according to one of the following: (1) Air shall be permitted via noncombustible ductwork to be transferred from adjacent spaces, from outside the building, or from spaces that do not contain combustible or flammable materials via noncombustible ductwork (2) Air shall be permitted to be transferred from a corridor under the door up to the greater of 24 L/sec (50 cfm) or 15 percent of the room exhaust in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. (3) Supply air shall be permitted to be provided from any building ventilation system that does not contain flammable or combustible vapors. This deficient practice could affect all residents, staff and visitors.		meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 04/21/2025, the DON/Maintenance Supervisor replaced the exhaust fan in the wall near the ceiling of the oxygen storage/transfilling room to meet set standards. The Administrator verified the work on 04/21/2025. b On 05/05/2025 the DON/Maintenance Supervisor removed the transition strip down to the concrete floor in the oxygen storage/transfilling room to meet set standards. The Administrator verified the work on 05/05/2025. c On 05/05/2025the DON/Maintenance Supervisor marked an area for empty cylinders and marked an area for full containers in the oxygen storage/transfilling room to meet set standards. The Administrator verified the work on 05/05/2025. 2 **ALL OTHERS WITH POTENTAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: 1.On 04/23/2025, the Administrator inserviced the DON/and all nursing staff/Maintenance Supervisor to ensure oxygen storage/transfilling rooms are provided with properly working mechanical ventilation and ensure oxygen cylinders are	

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	Findings include: Based on observation with the Maintenance Director at 1:06 p.m. on 04/21/2025, the floor under the oxygen storage/transfilling room had a rubber type transition between the corridor floor and the concrete floor in the oxygen storage/transfilling room. The rubber type transition prevented make-up air from the corridor to the oxygen storage/transfilling room. No other means of make-up air was observed in the oxygen storage/transfilling room. Based on interview with the Maintenance Director at 1:06 p.m. on 04/21/2025, he acknowledged no means of make-up air was provided. 3.) Based on observation and interview, the facility failed to ensure oxygen cylinders were segregated by full and empty and were marked to avoid confusion. NFPA 99, Section 11.6.5.2 states, if empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Section 11.6.5.3 states empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner. This deficient practice could affect all residents and staff. Findings include: Based on observation with the Maintenance Director at 1:06 p.m. on 04/21/2025, oxygen storage/transfilling room had more than 10 oxygen cylinders/containers each that were not marked or separated as full and empty cylinders. Based on observation with a Qualified Medication Aide (QMA) and the Maintenance Director at 1:08 p.m., no means of segregating empty and full oxygen cylinders/containers was available. Based on		segregated by fully and empty to meet set standards. 2.Maintenance Supervisor/DON will ensure oxygen storage/transfilling rooms are provided with properly working mechanical ventilation and ensure oxygen cylinders are segregated by fully and empty as a part of the facility's Oxygen Policy and Procedures and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/DON/designee will review with the Administrator the inspection results. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the DON/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. Paper compliance is requested secondary to no harm or incident was reported.	

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	interview with a Qualified Medication Aide (QMA) at 1:08 p.m., he did not know which cylinders/containers were full or empty and stated he leaves the empty containers for the oxygen vendor to replace with full containers. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)			