STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155788	A. BUILDING -- B. WING	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD MEADOWS	1200 N STATE ROAD 135 GREENWOOD, IN 46142

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/07/24 Facility Number: 012564 Provider Number: 155788 AIM Number: 201018510 At this Emergency Preparedness survey, Greenwood Meadows was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 169 certified beds. At the time of the survey, the census was 135. Quality Review completed on 10/09/24	E 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a Post Survey Revisit on or after 10/31/24.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/07/24 Facility Number: 012564 Provider Number: 155788 AIM Number: 201018510 At this Life Safety Code survey, Greenwood Meadows was found not in compliance with	K 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a Post Survey Revisit on or after 10/31/24.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Carter	Executive Director	10/20/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hardwired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 169 and had a census of 135 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 10/09/24			
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Based on observation and interview, the facility failed to meet the clear width requirement for 1of 7 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor.	K 0232	K232 (E) Aisle, Corridor or Ramp Width **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·The Maintenance Director/designee moved the chair from one side of the hallway to the other on 10/14/24. All furniture is located on one side of the hallway. ·All furniture is affixed to the wall.	10/30/2024

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	(d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during the initial walk through of the facility from 9:15 a.m. to 9:25 a.m. on 10/07/24, furniture was stored on both sides of the corridor up against the corridor wall outside resident sleeping Room 120 and Room 123 in the 100 Hall. Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 1:00 p.m. to 2:50 p.m. on 10/07/24, the furniture was still stored in the corridor outside resident sleeping room 120 and 123. The sofa outside Room 120 and the chair outside Room 123 were both affixed to the wall and restricted the clear and unobstructed corridor width to six feet. Based on interview at the time of the observations, the Maintenance Director and		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents residing on 100 hall have the potential to be affected by this deficient practice. ·The furniture was moved to one side of the 100 hallway and affixed to the wall by the Maintenance Director/designee 10/14/24. ·All halls were observed by Maintenance Director/designee to ensure no furniture corridors are unobstructed with 6 feet width. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·The furniture was moved to one side of the hall and affixed to the wall by the Maintenance Director/designee 10/14/24. ·Maintenance Director/designee will complete the POC daily rounding tool to ensure corridors are unobstructed. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The Life Safety POC QAPI Tool will be utilized by Maintenance	

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	the Field Maintenance Supervisor agreed furniture was stored on both sides of the corridor in the 100 Hall. These findings were reviewed with the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		Director/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Based on observation and interview, the facility failed to ensure 1 of 1 battery powered emergency lighting systems was maintained in accordance with LSC Section 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70, National Electric Code. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 1:00 p.m. to 2:50 p.m. on 10/07/24, the battery operated lighting system installed inside the weatherproof shell for the emergency generator located outside the building on the northwest side of the property failed to illuminate when its respective power plug was removed from the electrical outlet inside the weatherproof shell multiple times. Based on interview at the time of the observations, the	K 0291	K 291 (F) Emergency Lighting **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·IEI was contacted for service. IEI diagnosed battery issue on 10/15/24. The battery was ordered and will be replaced by IEI once received. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by this deficient practice. ·The Maintenance Director/designee will check the battery-operated emergency lighting system on the generator weekly. **What measures will be put into**	10/30/2024

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	Maintenance Director stated the battery powered emergency lighting system does not have a test switch, he tests it monthly by unplugging its power cord and agreed the battery light failed to illuminate when tested. These findings were reviewed with the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b))		**place or what systemic changes you will make to ensure that the deficient practice does not recur.** ·The Maintenance Director will check the battery-operated emergency lighting system on the generator weekly. ·The Maintenance Director/designee will complete the Preventative Maintenance task for the generator's emergency lighting every month. ·The Executive Director/designee will review the TELS completion monthly for compliance. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The Life Safety POC QAPI Tool will be utilized by Maintenance Director/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing			

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	Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1 states that all valves shall be inspected weekly. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents and staff in the facility. Findings include: Based on record review with the Director of Property Management, the Maintenance Director and the Field Maintenance Supervisor from 9:25 a.m. to 12:45 a.m. on 10/07/24, monthly wet sprinkler gauge inspection documentation for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated the facility has both wet and dry sprinkler systems and agreed monthly wet sprinkler gauge inspection documentation for the most recent twelve month period was not available for review. Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 1:00 p.m. to 2:50 p.m. on 10/07/24, the facility has two wet sprinkler systems and two dry sprinkler systems.	K 0353	**K 353 (F) Sprinkler System/Maintenance and Testing** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Maintenance Director/designee checked the wet sprinkler system on 10/14/24 and completed documentation. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. A monthly Preventative Maintenance task was added to the TELS program to test the wet sprinkler system every month. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** A monthly Preventative Maintenance task was added to the TELS program to test the wet sprinkler system every month.	10/30/2024

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	These findings were reviewed with the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		The Maintenance Director/designee will complete the wet sprinkler system testing monthly and document completion in the TELS system. The Executive Director/designee will review TELS completion monthly for compliance. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Life Safety POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
K 0355 SS=D Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to ensure 1 of 23 portable fire extinguishers was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines	K 0355	**K 355 (D) Portable Fire Extinguishers** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	10/30/2024

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	extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect all kitchen staff. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 1:00 p.m. to 2:50 p.m. on 10/07/24, the fire extinguisher inspection contractor had affixed a hanging tag to the wall mounted ABC type portable fire extinguisher in the dish room in the kitchen indicating the most recent annual inspection was performed in February 2023. The facility continued to document monthly inspections on the hanging tag through September 2024. Based on interview at the time of the observations, the Maintenance Director and the Field Maintenance Supervisor agreed the most recent annual inspection for the aforementioned portable fire extinguisher was more than one year old. These findings were not reviewed with the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		**practice?** Whitlock completed the annual test on 3/18/2024 for the extinguisher in question. Whitlock was contacted and provided a new tag on 10/15/24. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director/designee will check all fire extinguishers for updated tags and annual testing. The Maintenance Director/designee will contact the testing company if new tags are needed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director/designee will edit the Preventative Maintenance annual task in TELS to include checking the extinguishers for new tags annually. The Maintenance Director/designee will ensure annual testing for extinguishers is completed and documented on the tag and in the TELS Preventative Maintenance system.	

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			The Executive Director will review the TELS Preventative Maintenance documentation monthly for compliance. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Life Safety POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
K 0522 SS=D Bldg. 01	NFPA 101 HVAC - Any Heating Device Based on observation and interview, the facility failed to ensure 1 of 1 dryer rooms was continuously provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for all staff in the vicinity of the room. This deficient practice could affect over two staff visitors in the Laundry. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor	K 0522	**K522 (D) HVAC/Any Heating Device** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** CH Mechanical was contacted by the Maintenance Director/designee to synchronize	10/30/2024

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	during a tour of the facility from 1:00 p.m. to 2:50 p.m. on 10/07/24, two wall mounted electrically powered Louvre systems were installed in an outside wall behind the natural gas fired dryers in the dryer room area of the Laundry to provide the dryers with intake air from the outside. Wooden two by fours were inserted in between slats for both Louvre systems to keep the systems opened to allow the dryers to be provided with make-up air. When the two by fours were removed, the slats closed and did not open electrically when the dryers were turned on. Based on interview at the time of the observations, the Maintenance Director stated new dryers were installed last week, the electrically powered Louvre systems are not synchronized to open with dryer activation and agreed it could not be assured the natural gas fired dryers would be continually provided with combustion air taken directly from the outside. These findings were reviewed with the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		the Louvre systems to open with dryer activation on 10/14/24. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice CH Mechanical was contacted by the Maintenance Director/designee to synchronize the Louvre systems to open with dryer activation on 10/14/24. The Maintenance Director/designee will add a monthly task in the Preventative Maintenance TELS system to check function of the Louvre systems. The Laundry staff will be educated by the Maintenance Director/designee to observe the Louvre system, and to contact Maintenance immediately if concerns are identified. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director/designee will add a monthly task in the Preventative Maintenance TELS system to check function of the Louvre systems. The Maintenance	

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			Director/designee will check the function of the Louvre systems monthly and document completion in TELS Preventative Maintenance system. The Executive Director will review the TELS Preventative Maintenance system monthly for documentation completion. The Laundry staff will be educated by the Maintenance Director/designee to observe the Louvre system, and to contact Maintenance immediately if concerns are identified. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Life Safety POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Based on observation and interview, the facility failed to ensure 2 of over 50 corridor doors were maintained in accordance with 19.7.5.6. 19.7.5.6 states combustible decorations shall be prohibited	K 0753	**K753 (E) Combustible**	10/30/2024

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	in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 19.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. (5)*They are decorations, such as photographs		**Decorations** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·The paper sheets were removed from the doors of the Staff Development office and Therapy Gym immediately on 10/7/2024 by the Maintenance Director/designee. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents residing in the facility have the potential to be affected by this deficient practice. ·The Department Managers will be educated on the hanging of signs by the Executive Director/designee. ·Maintenance Director/ designee rounded the facility to ensure no other untreated paper decorations were placed on door. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Department Managers will be educated on the hanging of signs by the Executive Director/designee.	

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	155788	A. BUILDING 01 B. WING	10/07/2024

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	and paintings, in such limited quantities that a hazard of fire development or spread is not present. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 1:00 p.m. to 2:50 p.m. on 10/07/24, paper sheets measuring 8.5 inches by eleven inches were affixed to the corridor side of the corridor door to the Staff Development Office in the 200 Hall. The paper sheets covered approximately 40 to 50 percent of the face of the corridor door. In addition, paper signage and artwork were affixed to the corridor side of the corridor door the Therapy Gym from the 400 Hall. The paper signage and artwork covered approximately 50 percent of the face of the corridor door. Based on interview at the time of the observations, the Maintenance Director stated the paper sheets, signage and artwork were not treated with fire retardant material and agreed that the affixed items exceeded 30 percent of the face of the corridor doors. These findings were not reviewed with the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		The ED/designee will meet with Resident Council President/Council to review the hanging paper on doors. The Maintenance Director/designee will round the facility using a POC rounding tool to ensure paper decorations are not hung on doors. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Life Safety POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on record review, observation and interview; the facility failed to ensure the proper operation was maintained for 1 of 1 rolling steel	K 0761	**K761 (E)**	10/30/2024

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	fire door was in accordance with NFPA 80. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 2010 Edition, the Standard for Fire Doors and Other Opening Protectives, Section 11.4.1.1 requires an automatic-closing device shall be installed on every rolling steel door. Section 11.4.1.2 states rolling steel doors shall close automatically upon activation or release of a fusible link or detector. Section 11.4.2.2.1 states that after the automatic closing is activated, the door shall remain in the closed position until the automatic-closing device has been reset. This deficient practice could affect over 20 residents, staff and visitors in the main Dining Room. Findings include: Based on review of the rolling fire door inspection contractor's "Fire Door Drop Test" documentation dated 04/28/23 with the Director of Property Management, the Maintenance Director and the Field Maintenance Supervisor from 9:25 a.m. to 12:45 a.m. on 10/07/24, "NA" was listed as the results of "Drop Test 1" and "Drop Test 2". Review of the rolling fire door inspection contractor's "Fire Door Drop Test" documentation dated 03/25/24 indicated "Drop Test 1" and "Drop Test 2" passed testing. Based on interviews at the time of record review, the Director of Property Management and the Maintenance Director stated the rolling fire door is not connected to the fire alarm system, it is not self-closing or automatic closing and only closes by manually pulling the		**Maintenance Inspection & Testing/Doors** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·IEI and Overhead Door were contacted on 10/17/24 by the Maintenance Director/designee to install an automatic closing device to the rolling steel door located between the kitchen and Main Dining room. ·The rolling steel door will be added to the current fire system. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents residing in the facility have the potential to be affected by the deficient practice. ·IEI and Overhead Door were contacted on 10/17/24 by the Maintenance Director/designee to install an automatic closing device to the rolling steel door located between the kitchen and Main Dining room. ·The rolling steel door will be added to the current fire system. ·The Maintenance Director/designee will test the	

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	door down. Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 1:00 p.m. to 2:50 p.m. on 10/07/24, the metal rolling fire door between the kitchen and main Dining Room was not equipped with a fusible link and was not self-closing or automatic closing. These findings were reviewed with the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		system monthly and document completion in the Preventative Maintenance TELS system. ·Whitlock will complete annual testing. The completed testing will be documented annually in the Preventative Maintenance TELS system. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·The Maintenance Director/designee will test the system monthly and document completion in the Preventative Maintenance TELS system. ·Whitlock will complete annual testing. The completed testing will be documented annually in the Preventative Maintenance TELS system. ·The Executive Director/designee will review the Preventative Maintenance TELS system monthly for completion of documentation. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Life Safety POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year	

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			with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	