STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155278	A. BUILDING -- B. WING	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER	155 E BURKS DR BLOOMINGTON, IN 47401

(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: 05/05/25 Facility Number: 000177 Provider Number: 155278 AIM Number: 100289860 At this Emergency Preparedness survey, Brickyard Healthcare-Bloomington Care Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 153 certified beds, with a current census of 122. Quality Review completed on 05/09/25 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	
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 and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). 1. Based on record review and interview, the facility failed to ensure a written record of weekly	E 0041	**1 What corrective action will be accomplished for those resident found to have been affected by the deficient practice?** Maintenance has been trained on how to access the TELS records **2 How other residents having the potential to be**	06/27/2025

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

Mary Oliver | VP Regulatory Compliance | 06/12/2025

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

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	inspections for 1 of 1 generator was maintained for 21 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection and testing reports on 05/05/25 at 1:34 p.m. with the Executive Director and Maintenance Director present, there was no documentation available to show the emergency generator was inspected/tested weekly for 21 of the past 52 weeks. Based on interview at 1:34 p.m., the Maintenance Director said the weekly inspections/tests were performed each week, but he was unable to access the information from the TELS computer program the facility uses for preventative maintenance tasks for the weeks that there was no documentation available to review. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.		**affected by the same deficient practice** All residents have potential to be affected by this alleged deficient practice. **3 What measures will be put into place and what systemic changes will be made?** Weekly generator tests are now being conducted per the schedule and documented. Monthly generator tests under load are being conducted per the schedule and a load bank test has been conducted. A four hour run test of the generator was conducted. **4 How the corrective action will be monitored to ensure the deficient practice will not recur** A Task has been added to TELS to conduct the weekly inspection of the generator, the monthly test under load, the annual load bank testing, and the 4 hour run test every 36 months. Maintenance will report to QAPI in perpetuity regarding life safety items. **5 By what date the systemic changes for each deficiency will be completed?** June 27, 2025	

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	2. Based on record review and interview, the facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 05/05/25 at 12:40 p.m. with the Executive Director and Maintenance Director present, the monthly load percentage for the diesel powered generator was documented less than 30% during 3 of the past 12 month period. Based on interview at the time of record review, the Maintenance Director acknowledged the generator ran under load on a monthly basis and did not achieve 30% of the name plate rating for 3 of the past 12 month period. Additionally, the Maintenance Director acknowledged a load			

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	bank test for the generator has not occurred within the past 12 month period. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3. Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years (36 months). Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: Based on record review on 05/05/25 at 12:40 p.m. with the Executive Director and Maintenance Director present, the facility was unable to provide documentation of a four hour load test of the emergency generator conducted within the past 36 month period. This was confirmed by the Maintenance Director at the time of record review. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.			

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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: 05/05/25 Facility Number: 000177 Provider Number: 155278 AIM Number: 100289860 At this Life Safety Code survey, Brickyard Healthcare -Bloomington Care Center was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has battery powered smoke alarms installed in all resident sleeping rooms. The facility has a capacity of 153 and had a census of 122 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 05/09/25	K 0000	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	

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K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Based on observation and interview, the facility failed to ensure 2 of 10 exit means of egress were continuously maintained free of obstructions. This deficient practice could at least 30 residents, staff, and visitors. Findings include: Based on observations on 05/05/25 during a tour of the facility with the Executive Director and Maintenance Director, the following was noted: a. At 2:25 p.m., there were two metal chairs outside the Horizon's west unit exit doors, making opening the doors difficult and blocking the path to egress. This was acknowledged by the Maintenance Director at 2:25 p.m. b. At 2:39 p.m., there was one metal chair outside the Horizon's north unit exit doors, making opening the doors difficult and blocking the path to egress. This was acknowledged by the Maintenance Director at 2:39 p.m. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)	K 0211	**1 What corrective action will be accomplished for those resident found to have been affected by the deficient practice?** The two metal chairs outside Horizons unit were removed that were blocking the path to egress and the one metal chair was removed from the Horizons North exit doors that were making the doors difficult to open and blocking the path of egress. **2 How other residents having the potential to be affected by the same deficient practice** All residents in the vicinity could potentially be affected by the alleged deficient practice. **3 What measures will be put into place and what systemic changes will be made?** A weekly task was added to TELS with the following steps: Check general condition of exterior. Check sidewalks to make sure they are passable without obstruction such as changes in elevation due to heaving, cracking, aggregates, or any other objects that would cause safe passage to be hindered. Check exterior lighting to ensure it is in place to appropriately cover the length of the walkway with appropriate	06/27/2025

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			candlepower. Check that exterior signage is in place such as the FDC sign and Exit signs in courtyards and that they direct to the appropriate areas and are fully visible. Check condition of gate hardware and electronics to ensure they are in working and safe condition with no breakage or exposed wires. Ensure exit doors are not obstructed with chairs, milk crates or other obstructions on the outside and the interior of the facility. **4 How the corrective action will be monitored to ensure the deficient practice will not recur** Maintenance will report to QAPI no less than quarterly in perpetuity regarding life safety items **5 By what date the systemic changes for each deficiency will be completed?** June 27, 2025	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the keypad to 1 of 1 courtyard gate was properly maintained. This deficient practice could affect at least 10 residents, as well as staff and visitors. Findings include: Based on observation on 05/05/25 at 2:32 p.m. during a tour of the facility with the Executive Director, Maintenance Director, and Maintenance	K 0222	**1 What corrective action will be accomplished for those resident found to have been affected by the deficient practice?** The keypad to the magnetic lock for the Horizons gate was re-attached to the conduit and repaired to cover exposed wires and was reattached. **2 How other residents**	06/27/2025

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	Assistant, the courtyard gate from the two Horizon's Unit exits and REM Unit exit was equipped with a magnetic lock which did require the use of a key at the keypad to release the magnetic lock. When the Maintenance Assistant used his key in the keypad the magnetic lock did release the gate to open, however, the keypad had pulled away from the plastic conduit and exposed wires between the keypad and the conduit. Furthermore, there was an extension of the conduit from the keypad where it entered the building through the soffit that also had pulled away from the soffit and exposed wires. This was acknowledged by the Executive Director and Maintenance Director at 2:32 p.m. at the time of observation. The Maintenance Director said he was unaware of the exposed wires to the keypad. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		**having the potential to be affected by the same deficient practice** This alleged deficient practice could potentially affect the residents using the Horizons courtyard. **3 What measures will be put into place and what systemic changes will be made?** A weekly task was added to TELS with the following steps: Check sidewalks to make sure they are passable without obstruction such as changes in elevation due to heaving, cracking, aggregates, or any other objects that would cause safe passage to be hindered. Check exterior lighting to ensure it is in place to appropriately cover the length of the walkway with appropriate candlepower. Check that exterior signage is in place such as the FDC sign and Exit signs in courtyards and that they direct to the appropriate areas and are fully visible. Check condition of gate hardware and electronics to ensure they are in working and safe condition with no breakage or exposed wires. ensure exit doors are not obstructed with chairs, milk crates or other obstructions on the outside and the interior of the facility. **4 How the corrective action will be monitored to**	

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			ensure the deficient practice will not recur Maintenance will report to QAPI no less than quarterly in perpetuity regarding life safety issues. **5 By what date the systemic changes for each deficiency will be completed?** June 27, 2025	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Based on observation and interview, the facility failed to maintain the walking surface for 2 of 10 exit discharge areas. This deficient practice could affect at least 30 residents, as well as staff and visitors. Findings include: Based on observations on 05/05/25 during a tour of the facility with the Executive Director and Maintenance Director, the following was noted: a. At 2:49 p.m., the sidewalk outside the Horizon's north unit had a two inch gap between slabs, furthermore, there was a grade change of one to two inches from one slab to the next in the same area. The two inch gap and level change on the sidewalk to the public way could be a tripping hazard while exiting from this area in the event of an emergency. This was acknowledged by the Maintenance Director at 2:49 p.m. b. At 3:17 p.m., the side walk approximately 20 feet outside the REM unit east exit door had an eight foot section covered with rocks and mud which would be difficult to traverse in the event of an evacuation from this section of the facility. This was acknowledged by the Maintenance Director at 3:17 p.m.	K 0271	**1 What corrective action will be accomplished for those resident found to have been affected by the deficient practice?** The sidewalk outside the Horizons North unit 2 inch gap was repaired to prevent a tripping hazard and the rocks and mud were cleared from the approximately 8 foot section located 20 feet outside the REM unit. **2 How other residents having the potential to be affected by the same deficient practice** This deficient practice could potentially affect residents exiting the REM unit. **3 What measures will be put into place and what systemic changes will be made?** A weekly task was added to TELS with the following steps: Check sidewalks to make sure they are passable without	06/27/2025

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	This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		obstruction such as changes in elevation due to heaving, cracking, aggregates, or any other objects that would cause safe passage to be hindered. Check exterior lighting to ensure it is in place to appropriately cover the length of the walkway with appropriate candlepower. Check that exterior signage is in place such as the FDC sign and Exit signs in courtyards and that they direct to the appropriate areas and are fully visible. Check condition of gate hardware and electronics to ensure they are in working and safe condition with no breakage or exposed wires. ensure exit doors are not obstructed with chairs, milk crates or other obstructions on the outside and the interior of the facility. **4 How the corrective action will be monitored to ensure the deficient practice will not recur** Maintenance will report to QAPI no less than quarterly in perpetuity regarding life safety issues. **5 By what date the systemic changes for each deficiency will be completed?** June 27, 2025	
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Based on observation and interview, the facility failed to ensure the lighting for 2 of 10 exit means	K 0281	**1 What corrective action will be accomplished for those**	06/27/2025

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	of egress was properly maintained and would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect at least 30 residents as well as staff and visitors. Findings include: Based on observations on 05/05/25 at 2:47 p.m. during a tour of the facility with the Executive Director and Maintenance Director, the sidewalk from the Horizon's Unit north exit to the courtyard gate was about 150 feet in length. There was not adequate lighting along the sidewalk to the courtyard gate and beyond to the public way. This sidewalk would also effect residents and staff that might need to evacuate the REM Unit east exit in the event of an emergency. This was acknowledged by the Executive Director and Maintenance Director at 2:47 p.m. at the time of observation. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		**resident found to have been affected by the deficient practice?** The sidewalk from the horizons unit North and the REM unit had double flood light fixtures added to cover areas that did not already have sufficient lighting. **2 How other residents having the potential to be affected by the same deficient practice** All residents using the horizons unit North and REM exits have potential to be affected by the alleged deficient practice. **3 What measures will be put into place and what systemic changes will be made?** A weekly task was added to TELS with the following steps: Check general condition of exterior. Check sidewalks to make sure they are passable without obstruction such as changes in elevation due to heaving, cracking, aggregates, or any other objects that would cause safe passage to be hindered. Check exterior lighting to ensure it is in place to appropriately cover the length of the walkway with appropriate candlepower. Check that exterior signage is in place such as the FDC sign and Exit signs in courtyards and that they direct to the appropriate areas and are fully visible.	

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			Check condition of gate hardware and electronics to ensure they are in working and safe condition with no breakage or exposed wires. ensure exit doors are not obstructed with chairs, milk crates or other obstructions on the outside and the interior of the facility. **4 How the corrective action will be monitored to ensure the deficient practice will not recur** Maintenance will report to QAPI no less than Quarterly in perpetuity regarding life safety issues. **5 By what date the systemic changes for each deficiency will be completed?** June 27, 2025	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Based on observation and interview, the facility failed to maintain exit signage within 1 of 1 courtyard in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect at least 30 residents, as well as staff and visitors if needing to exit through the courtyard.	K 0293	**1 What corrective action will be accomplished for those resident found to have been affected by the deficient practice?** The exit on the wood fence outside the Horizons unit was replaced with a new exit sign with a proper directional arrow pointing to the proper egress. The courtyard gate outside the Horizons unit west exit was provided with a new exit sign. An exit sign with a directional arrow was added outside the REM unit	06/27/2025

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	Findings include: Based on observations on 05/05/25 during a tour of the facility with the Executive Director and Maintenance Director, the following was noted: a. At 2:40 p.m., the letters and directional arrow on the exit sign on the wood fence outside the Horizon's Unit north exit, and within the courtyard, was damaged and missing a portion of the letters. This was confirmed by the Maintenance Director at 2:40 p.m. b. At 2:44 p.m., the courtyard gate outside the Horizon's Unit west exit was not provided with an EXIT sign. This was confirmed by the Maintenance Director at 2:44 p.m. c. At 3:15 p.m., there was no exit sign with a directional arrow outside the REM Unit east exit to lead residents and staff to the courtyard gate near the Horizon's Unit west exit. This was confirmed by the Maintenance Director at 3:15 p.m., furthermore, the exit sign was found on the sidewalk near the exit door. The Maintenance Director said a new fence was recently installed and the installers forgot to put the exit sign back on the fence outside the exit door. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		east exit to lead residents and staff to the courtyard gate near the horizons unit west exit. The exit sign that was on the ground found on the sidewalk from the new fence was replaced to it's proper place. **2 How other residents having the potential to be affected by the same deficient practice** All residents in the vicinity could potentially be affected by the alleged deficient practice. **3 What measures will be put into place and what systemic changes will be made?** A weekly check was added to TELS with the following steps: Check general condition of exterior. Check sidewalks to make sure they are passable without obstruction such as changes in elevation due to heaving, cracking, aggregates, or any other objects that would cause safe passage to be hindered. Check exterior lighting to ensure it is in place to appropriately cover the length of the walkway with appropriate candlepower. Check that exterior signage is in place such as the FDC sign and Exit signs in courtyards and that they direct to the appropriate areas and are fully visible. Check condition of gate hardware and electronics to ensure they are in working and safe condition with no breakage or	

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			exposed wires. Ensure exit doors are not obstructed with chairs, milk crates or other obstructions on the outside and the interior of the facility. **4 How the corrective action will be monitored to ensure the deficient practice will not recur** Maintenance will report to QAPI no less than Quarterly in perpetuity regarding life safety issues. **5 By what date the systemic changes for each deficiency will be completed?** June 27, 2025	
K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings - Enclosure Based on observation and interview, the facility failed to ensure the protection of 1 of 4 stairway doors was in accordance of 19.3.1. LSC 19.3.1 requires vertical opening shall be enclosed or protected in accordance with Section 8.6. LSC 8.6.1 requires every floor that separates stories in a building shall be constructed as a smoke barrier. LSC 8.7.1.3 requires doors in barriers required to have a fire resistive rating shall have a minimum ¾ hour fire protection rating and be self-closing or automatic closing. This deficient practice could affect at least 10 residents and staff in the Station 2 Back Hall. Findings include: Based on observation on 05/05/25 at 3:34 p.m. during a tour of the facility with the Executive Director and Maintenance Director, the Station 2	K 0311	**1 What corrective action will be accomplished for those resident found to have been affected by the deficient practice?** The station 2 back hall right side stairway door will be replaced with a new door or door set will be ordered. As the lead time often exceeds 12 weeks we will get the doors ordered and get an email or work order signed from the installing company to show they have been ordered prior to compliance date, however the install will likely surpass the compliance date. Due to the timeframe required to have this completed we are applying for a	06/27/2025

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	Back Hall right side stairway door was not provided with a fire rating tag. The lack of a fire rating tag was acknowledged by the Maintenance Director at 3:34 p.m.. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		temporary waiver. **2 How other residents having the potential to be affected by the same deficient practice** This alleged deficient practice could potentially affect all residents in the area of the station 2 back hall fire doors. **3 What measures will be put into place and what systemic changes will be made?** A task was added to TELS to check all fire doors annually and includes checking the labeling. **4 How the corrective action will be monitored to ensure the deficient practice will not recur** Maintenance will report to QAPI no less than Quarterly in perpetuity regarding life safety issues. **5 By what date the systemic changes for each deficiency will be completed?** June 27, 2025	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure 1. Based on observation and interview, the facility failed to ensure 1 of 1 egress corridor in the lower level/basement was not used to store combustible material. This deficient practice could affect mostly staff while in the lower level/basement. Findings include:	K 0321	**1 What corrective action will be accomplished for those resident found to have been affected by the deficient practice?** All boxes and combustible items stored in the basement hallways and corridors were removed. A	06/27/2025

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	Based on observation on 05/05/25 at 4:00 p.m. during a tour of the facility with the Executive Director and Maintenance Director, there were at least 20 cardboard boxes full of supplies stored on wood pallets along with other combustible items in the egress corridor in the lower level/basement. Based on interview at 4:00 p.m., the Executive Director and Maintenance Director acknowledged the combustible storage in the lower level/basement corridor and said they would have it moved to a protected area as soon as possible. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as a storage room door, was provided with a properly connected self closing device. This deficient practice could affect mostly staff while in the lower level/basement. Findings include: Based on observation on 05/05/25 at 4:05 p.m. during a tour of the facility with the Executive Director and Maintenance Director, the storage room door in the lower level/basement was provided with a self closing device at the top of the door, however, the self closing device was not attached to the door frame and did not close the door automatically when tested. The room was over 50 square feet in size and stored over 30 cardboard boxes full of supplies, Christmas supplies, plastic totes, paper, and plastic items and other combustible items. Based on interview		self-closer was added to the basement storage room door to ensure proper self-close and latch occurs. **2 How other residents having the potential to be affected by the same deficient practice** This alleged deficient practice could potentially affect all personnel in the area and therefore affect the residents served. **3 What measures will be put into place and what systemic changes will be made?** Central supply and Housekeeping will clear the incoming boxes as they come in from deliveries and maintenance will monitor and report to the Executive director in the morning meeting A weekly task was added to TELS with the following steps: Check hallway to ensure no carts or objects without wheels are present. Remove immediately if found. Ensure all departments remove all boxes or combustible materials immediately if found and report to the ED in morning meeting. Furniture of any kind should not be unsecured in hallway and should never obstruct the width of the hallway to less than 6 feet even if secured to the wall or the floor. Any of these items found need to be removed immediately. If it is recurring report to administration.	

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	at 4:05 p.m. at the time of observation, the Executive Director and Maintenance Director acknowledged the lack of a properly connected self closing device on the lower level storage room and said they were not aware the self closing device was not connected. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		A monthly task was added to TELS for storage areas over 50 square feet with the following steps: Ensure all areas used for storage of hazardous materials are equipped with a door closer and are self-latching. Ensure all areas over 50 square feet and are used for storage of flammable materials such as boxes or other flammable materials are equipped with a door closer and self-latch into the frame. **4 How the corrective action will be monitored to ensure the deficient practice will not recur** Maintenance will report to QAPI no less than quarterly in perpetuity regarding life safety issues. **5 By what date the systemic changes for each deficiency will be completed?** June 27, 2025	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities 1. Based on observation and interview, the facility failed to ensure staff were instructed in the proper use of the UL 300 hood fire suppression system in 1 of 1 kitchen. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 10.5.7 states instruction shall be provided to employees regarding the proper use of portable fire extinguishers and the manual activation of fire-extinguishing equipment. Section 11.1.4 states instructions for manually operating the fire	K 0324	**1 What corrective action will be accomplished for those resident found to have been affected by the deficient practice?** Employees in the kitchen were trained on the proper operational steps to extinguish a grease fire under the kitchen hood by activating the ansul system first and using the type K extinguisher	06/27/2025

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	extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect kitchen staff plus residents while in the adjoining dining room. Findings include: Based on observations on 05/05/25 at 4:31 p.m. during a tour of the facility with the Executive Director and Maintenance Director, the kitchen was provided with a UL 300 hood system. Based on interview with a cook, when asked what he would do first if there was a fire underneath the range hood and the range hood suppression system had not automatically activated, he said he would grab the K Class fire extinguisher. Furthermore, when asked if he knew where the range hood suppression pull station was located, he was able to go right to it. This was acknowledged by the Maintenance Director at 4:31 p.m. during the interview with the cook. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2, states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the		to extinguish any residual fire. **2 How other residents having the potential to be affected by the same deficient practice** All residents have potential to be affected by this deficient practice. **3 What measures will be put into place and what systemic changes will be made?** An all Dietary staff in-service was conducted to ensure kitchen staff have proper knowledge of locating and operating the hood fire suppression system. Dietary manager will train all new employees as they hire on. Dietary Manager will report to QAPI no less than quarterly on this life safety issue and training status of employees. Maintenance marked the floor where the kitchen equipment is to be returned to under the exhaust hood and the fire suppression hood nozzles were fully aligned with the cooking appliances A monthly TELS task was added with the following steps: Verify all kitchen cooking equipment designed to be under the ANSUL hood system have the wheel locations marked for a "return plan" as to denote exact location the equipment is to be placed in. Ensure hood suppression system nozzles are pointed directly at the equipment and have appropriate caps in place	

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	fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 states the fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 states an approved method shall be provided that will ensure that the appliance is returned to an approved design location. This deficient practice could affect kitchen staff plus residents while in the adjoining dining room. Findings include: Based on observations on 05/05/25 at 4:28 p.m. during a tour of the facility with the Executive Director and Maintenance Director, the oven/stove and flat grill located under the range hood in the kitchen were not provided with an approved method that would ensure that the appliances were returned to an approved designed location after they had been moved for maintenance and/or cleaning. Furthermore, the suppression nozzles for the cooking appliances were not fully aligned directly over the cooking surfaces. Based on interview at 4:28 p.m. the Maintenance Director was not aware an approved method had to be provided to ensure the appliances were returned to an approved designed location after maintenance or cleaning, and was not aware that the suppression nozzles were not fully aligned over the cooking appliances.		where applicable. Ensure drip pan or tray is in place at the bottom of the hood system. **4 How the corrective action will be monitored to ensure the deficient practice will not recur** Maintenance to report to QAPI no less than quarterly in perpetuity on life safety items. **5 By what date the systemic changes for each deficiency will be completed?** June 27, 2025	

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	This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)			
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 for the protection of all occupants indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants in the facility. Findings include: Based on record review on 05/05/25 at 10:00 a.m. with the Executive Director and Maintenance Director present, the facility did provide two fire watch policies from the Emergency Action Plan. They were both incomplete or inaccurate. The first, named "Fire Watch", failed to include contacting the IDOH with the web link for contacting the Incident Reporting System located on the IDOH Gateway. The second, named "Fire Alarm System Impairments", was not provided with the facility's current fire alarm system monitoring company, but was still listing the facility's previous fire alarm system monitoring company. Based on an interview at the time of record review, this was confirmed by the Executive Director. This finding was reviewed with the Executive Director and Maintenance Director during the exit	K 0346	**1 What corrective action will be accomplished for those resident found to have been affected by the deficient practice?** Proper fire watch policies were added which include contacting IDOH with the web link for the IDOH gateway and with the proper monitoring company information to the fire alarm system impairment and the fire protection system impairment pages in the EPP book. **2 How other residents having the potential to be affected by the same deficient practice** This alleged deficient practice could potentially affect all residents **3 What measures will be put into place and what systemic changes will be made?** Fire watch policies will be reviewed in the Executive director's annual review of the emergency preparedness manual to ensure compliance and	06/27/2025

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	conference. 3.1-19(b)		documented on the opening pages of the book. Maintenance and the interdisciplinary team will be a part of the annual review process. **4 How the corrective action will be monitored to ensure the deficient practice will not recur** Maintenance will report to QAPI in perpetuity led by the Executive director. **5 By what date the systemic changes for each deficiency will be completed?** June 27, 2025	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to provide an automatic sprinkler system that provided complete coverage in 1 of 1 dumbwaiter shaft. This deficient practice could affect at least 30 residents, staff, and visitors in the Station 2 Units. Findings include: Based on observation on 05/05/25 at 3:55 p.m. during a tour of the facility with the Executive Director and Maintenance Director, there was no sprinkler coverage that could be found within the Station 2 dumbwaiter shaft. Based on interview at 3:55 p.m., the Executive Director and Maintenance Director agreed there was no sprinkler coverage found within the dumbwaiter shaft. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.	K 0351	**1 What corrective action will be accomplished for those resident found to have been affected by the deficient practice?** Sprinkler coverage was installed in the dumbwaiter shaft. **2 How other residents having the potential to be affected by the same deficient practice** This alleged deficient practice has potential to affect all residents. **3 What measures will be put into place and what systemic changes will be made?** An annual sprinkler In-house inspection was added to tels to inspect the sprinkler system and the system is inspected quarterly	06/27/2025

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	3.1-19(b)		by a professional. **4 How the corrective action will be monitored to ensure the deficient practice will not recur** Maintenance will report to QAPI no less than quarterly in perpetuity regarding life safety issues **5 By what date the systemic changes for each deficiency will be completed?** June 27, 2025	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on observation and interview, the facility failed to ensure sprinkler heads in 3 of 8 smoke compartments and one outside overhang covered with corrosion or paint were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect at least 30 resident, as well as staff. Findings include: Based on observations on 05/05/25 during a tour of the facility with the Executive Director and Maintenance Director, the following was noted: a. At 2:16 p.m. there were two pendent sprinkler heads in the Horizon's Shower Room covered with	K 0353	**1 What corrective action will be accomplished for those resident found to have been affected by the deficient practice?** Sprinkler heads (2 in Horizons shower room, 2 in Horizons clean utility, and one in station 2 short hall environmental services water closet) were replaced One sprinkler head under the physical therapy hall outside exit overhang that was covered in corrosion was replaced. The TELS system was updated to document the appropriate “wet system” checks and all appropriate gauges are in place. Quick response sprinkler heads and standard response heads were added to the spare sprinkler head cabinet to represent the types found in the facility. The FDC sign was replaced and another added more visible to the	06/27/2025

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	corrosion. This was confirmed by the Maintenance Director at 2:16 p.m. b. At 2:53 p.m. there were two pendent sprinkler heads in the Horizon's Clean Utility Room partially covered with paint. This was confirmed by the Maintenance Director at 2:53 p.m. a. At 3:26 p.m. there was one pendent sprinkler head in the Station 2 Short Hall Environmental Services Water Closet covered with corrosion. This was confirmed by the Maintenance Director at 3:26 p.m. b. At 3:42 p.m. there was one pendent sprinkler head under the Physical Therapy hall outside exit overhang covered with corrosion. This was confirmed by the Maintenance Director at 3:42 p.m. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review, observation, and interview, the facility failed to properly document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 sprinkler systems. 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 the normal water 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 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections,		incoming drive with an arrow to indicate the location of the fire department connection. **2 How other residents having the potential to be affected by the same deficient practice** Thes alleged deficient practices could potentially affect all residents. **3 What measures will be put into place and what systemic changes will be made?** The following TELS tasks were added: Fire sprinkler coverage check every 6 months, Wet sprinkler gauge check monthly, Fire department connection (signage included) every 3 months, In house visual inspection Monthly (spare heads, valves, connections, gauges), Annual in house inspection for all sprinkler heads to include all damage, paint, corrosion. **4 How the corrective action will be monitored to ensure the deficient practice will not recur** Maintenance will report to QAPI no less than quarterly in perpetuity regarding life safety issues. **5 By what date the systemic changes for each deficiency will be completed?** June 27, 2025	

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	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, staff, and visitors in the facility. Findings include: Based on review of the sprinkler system inspection records on 05/05/25 at 12:00 p.m. with the Executive Director and Maintenance Director present, the sprinkler gauge inspection records for the past 12 month period listed two sprinkler gauges as being inspected monthly. One was listed as a "Water Pressure" gauge and the other was listed as an "Air Pressure" gauge. Based on interview at 12:00 p.m., when asked, the Maintenance Director said the sprinkler system was a wet system only. He further said one of the sprinkler gauges has been removed recently so it will no longer be documented anymore. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler system was provided with the minimum number of spare sprinklers in a spare sprinkler cabinet on the premises for the types and temperature ratings of the sprinklers on the property. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in			

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	any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations on 05/05/25 between 2:00 p.m. and 5:00 p.m. during a tour of the facility with the Executive Director and Maintenance Director, Quick Response and Standard Response pendent type sprinkler heads were installed in areas of the facility. Based on observation of the spare sprinkler head cabinet in the Sprinkler Riser Room at 4:35 p.m., there were no Quick Response pendent type sprinkler heads in the spare sprinkler cabinet or on the premises, furthermore, there was only one Standard Response pendent type sprinkler head in the spare sprinkler cabinet. Based on interview at 4:35 p.m., the Maintenance Director agreed the spare sprinkler cabinet did not contain enough Quick Response and Standard Response pendent type spare sprinkler heads. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b) 4. Based on observation and interview, the facility failed to ensure 1 of 1 fire department connection was in accordance with NFPA 25, 2011 Edition, Standard for the Inspection, Testing, and			

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	Maintenance of Water-Based Fire Protection Systems. Section 13.7.1 requires fire department connections to be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. This deficient practice could affect all occupants. Findings include: Based on observations on 05/05/25 at 4:45 p.m. during a tour of the facility with the Executive Director and Maintenance Director, the facility's fire department connection (FDC) was located on the wall outside of the lower level of the facility. There was an FDC sign provided at the fire department connection, however, the sign was almost completely faded and the "FDC" was no longer evident. Furthermore, there was a parking area lined with trees near the entrance road to the facility, so the fire department connection was not visible from that entrance road. There was no further signage on the facility wall or on a post with a directional arrow pointing to the fire department connection for the responding fire department to lead them to the fire department connection for easy identification. Based on interview at the time of observation, this was acknowledged by the Maintenance Director who agreed there should be a new FDC sign over the			

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	fire department connection and another sign with a directional arrow pointing to the fire department connection. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)			
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 containing procedures to be followed for the protection of all residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include:	K 0354	**1 What corrective action will be accomplished for those resident found to have been affected by the deficient practice?** Proper fire watch policies were added which include contacting IDOH with the web link for the IDOH gateway and with the proper monitoring company information to the fire alarm system impairment and the fire protection system impairment pages in the EPP book. **2 How other residents having the potential to be affected by the same deficient practice** This alleged deficient practice could potentially affect all residents **3 What measures will be put into place and what systemic changes will be made?** Fire watch policies will be reviewed in the Executive	06/27/2025

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	Based on record review on 05/05/25 at 10:00 a.m. with the Executive Director and Maintenance Director present, the facility did provide two fire watch policies from the Emergency Action Plan. They were both incomplete or inaccurate. The first, named "Fire Watch", failed to include contacting the IDOH with the web link for contacting the Incident Reporting System located on the IDOH Gateway, and did not include information about contacting the facility's insurance carrier with a contact number. The second, named "Fire Alarm System Impairments", was not provided with the facility's current fire alarm system monitoring company, but was still listing the facility's previous fire alarm system monitoring company. Based on an interview at the time of record review, this was confirmed by the Executive Director. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		director's annual review of the emergency preparedness manual to ensure compliance and documented on the opening pages of the book. Maintenance and the interdisciplinary team will be a part of the annual review process. **4 How the corrective action will be monitored to ensure the deficient practice will not recur** Maintenance will report to QAPI in perpetuity led by the Executive director. **5 By what date the systemic changes for each deficiency will be completed?** June 27 2025	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Based on observation and interview, the facility failed to ensure 1 of over 5 resident areas open to the corridor were separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised	K 0361	**1 What corrective action will be accomplished for those resident found to have been affected by the deficient practice?** A smoke detector was added to the REM unit activity room wired into the facility fire alarm system **2 How other residents having the potential to be affected by the same deficient practice**	06/27/2025

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	automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect at least 10 residents, as well as staff and visitors. Findings include: Based on observation on 05/05/25 at 3:05 p.m. during a tour of the facility with the Executive Director and Maintenance Director, the REM Unit Activity Room was open to the egress corridor without full direct supervision from a 24 hour station (Nurse's Station). Furthermore, LSC 19.3.6.1(7) was not met because the REM Unit Activity Room was not protected by an electrically supervised automatic smoke detection system. Based on interview at 3:05 p.m., the Maintenance Director said the door to the Activity Room was removed a while back, and agreed it was not provided with an electrically supervised automatic smoke detector or a door to the egress corridor and was not directly supervised by a 24 hour station (Nurses' Station). This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		This alleged deficient practice could affect all residents **3 What measures will be put into place and what systemic changes will be made?** A full facility audit was completed to ensure all areas open to the corridor have adequate fire alarm system coverage. **4 How the corrective action will be monitored to ensure the deficient practice will not recur** Maintenance will report to QAPI no less than quarterly on the alleged deficient practice. **5 By what date the systemic changes for each deficiency will be completed?** June 27, 2025	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills 1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 2 of 3 shifts during 2 of 4 quarters. This deficient practice could affect all residents, as well as staff and visitors in the	K 0712	**1 What corrective action will be accomplished for those resident found to have been affected by the deficient practice?**	06/27/2025

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	facility. Findings include: Based on review of the facility's fire drill reports on 05/05/25 at 11:30 a.m. with the Executive Director and Maintenance Director present, there was no fire drill documentation available for the following shifts and quarters: a. Second shift (evening) of the third quarter (July, August, and September) of 2024. b. First shift (day) of the fourth quarter (October, November, and December) of 2024. Based on interview at the time of record review, the Maintenance Director acknowledged there were no fire drill reports available to review for the previously mentioned shifts and quarters. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c) 2. Based on record review and interview, the facility failed to ensure the documentation for 8 of 13 fire drills was accurate. This deficient practice could affect all residents in the facility. Findings include: Based on interview and record review on 05/05/25 at 11:30 a.m., when asked, the Maintenance Director said the shift times for the fire drills were as follows: first shift (7:00 a.m. to 3:00 p.m.), second shift (3:00 p.m. to 11:00 p.m.), and third shift (11:00 p.m. to 7:00 a.m.). These time frames were also listed on some of the older fire drill reports. Based on review of the fire drill reports		Fire drills are being conducted once per shift per quarter at varying times and places as well as different times per month and at the proper shift times. **2 How other residents having the potential to be affected by the same deficient practice** All residents have potential to be affected by the alleged deficient practice. **3 What measures will be put into place and what systemic changes will be made?** Tasks have been added to TELS to conduct fire drills monthly in shift rotation per code. **4 How the corrective action will be monitored to ensure the deficient practice will not recur** Maintenance will report to QAPI no less than quarterly in perpetuity regarding life safety issues. **5 By what date the systemic changes for each deficiency will be completed?** June 27, 2025	

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	the following was noted: a. Fire Drill report for 05/31/24 was performed at 3:49 p.m. (listed as a 1st shift drill) b. Fire Drill report for 08/10/24 was performed at 7:30 p.m. (listed as a 1st shift drill) c. Fire Drill report for 10/26/24 was performed at 7:00 p.m. (listed as a 1st shift drill) d. Fire Drill report for 11/29/24 was performed at 2:30 p.m. (listed as a 2nd shift drill) e. Fire Drill report for 12/27/24 was performed at 10:15 p.m. (listed as a 3rd shift drill) f. Fire Drill report for 02/28/25 was performed at 2:30 p.m. (listed as a 2nd shift drill) g. Fire Drill report for 03/07/25 was performed at 9:00 p.m. (listed as a 3rd shift drill) h. Fire Drill report for 04/26/25 was performed at 8:00 p.m. (listed as a 3rd shift drill) Based on interview at 11:30 a.m., the Executive Director and Maintenance Director acknowledged the times the fire drills were performed during the past 12 month period and agreed they did not match the correct shifts according to the shift time frames provided. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)			
K 0761 SS=F Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of all fire door assemblies was completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be	K 0761	**1 What corrective action will be accomplished for those resident found to have been affected by the deficient practice?** All remaining fire door assemblies	06/27/2025

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	permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the		were inspected to include the two oxygen transfilling room fire door assemblies and four stairway fire door assemblies. **2 How other residents having the potential to be affected by the same deficient practice** All residents in the vicinity have potential to be affected by the alleged deficient practice. **3 What measures will be put into place and what systemic changes will be made?** A list of all fire door assemblies will be sent to TELS to populate the inspection logs for the next annual testing of the fire doors so none are missed. **4 How the corrective action will be monitored to ensure the deficient practice will not recur** Maintenance will report to QAPI no less than quarterly in perpetuity regarding life safety issues. **5 By what date the systemic changes for each deficiency will be completed?** June 27, 2025	

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	door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, as well as staff, and visitors. Findings include: Based on record review on 05/05/25 at 1:08 p.m. with the Executive Director and Maintenance Director present, the facility was unable to provide documentation for an annual inspection of all fire door assemblies for the past 12 month period. Based on interview at the time of record review, the Maintenance Director said there was no documentation of an annual inspection of all fire door assemblies available to review for the past 12 month period. Based on observations during a tour of the facility between 2:00 p.m. and 5:00 p.m., there were two oxygen transfilling room fire door assemblies and four stairway fire door assemblies in the facility. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste 1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 1 generator was maintained	K 0918	**1 What corrective action will be accomplished for those resident found to have been**	06/27/2025

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	for 21 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection and testing reports on 05/05/25 at 1:34 p.m. with the Executive Director and Maintenance Director present, there was no documentation available to show the emergency generator was inspected/tested weekly for 21 of the past 52 weeks. Based on interview at 1:34 p.m., the Maintenance Director said the weekly inspections/tests were performed each week, but he was unable to access the information from the TELS computer program the facility uses for preventative maintenance tasks for the weeks that there was no documentation available to review. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		**affected by the deficient practice?** Maintenance has been trained on how to access the TELS records. Weekly generator tests are now being conducted per the schedule and documented. Monthly generator tests under load are being conducted per the schedule and a load bank test has been conducted. A four hour run test of the generator was conducted. **2 How other residents having the potential to be affected by the same deficient practice** All residents have potential to be affected by this alleged deficient practice. **3 What measures will be put into place and what systemic changes will be made?** A Task has been added to TELS to conduct the weekly inspection of the generator, the monthly test under load, the annual load bank testing, and the 4 hour run test every 36 months. **4 How the corrective action will be monitored to ensure the deficient practice will not recur** Maintenance will report to QAPI in perpetuity regarding life safety items. **5 By what date the systemic changes for each deficiency will be completed?** June 27, 2025	

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	2. Based on record review and interview, the facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 05/05/25 at 12:40 p.m. with the Executive Director and Maintenance Director present, the monthly load percentage for the diesel powered generator was documented less than 30% during 3 of the past 12 month period. Based on interview at the time of record review, the Maintenance Director acknowledged the generator ran under load on a monthly basis and did not achieve 30% of the name plate rating for 3 of the past 12 month period. Additionally,			

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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
	the Maintenance Director acknowledged a load bank test for the generator has not occurred within the past 12 month period. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b) 3. Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years (36 months). Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: Based on record review on 05/05/25 at 12:40 p.m. with the Executive Director and Maintenance Director present, the facility was unable to provide documentation of a four hour load test of the emergency generator conducted within the past 36 month period. This was confirmed by the Maintenance Director at the time of record review. This finding was reviewed with the Executive Director and Maintenance Director during the exit			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	05/05/2025

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	conference. 3.1-19(b)			
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review, observation, and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice could affect all residents. Findings include:	K 0921	**1 What corrective action will be accomplished for those resident found to have been affected by the deficient practice?** PCREE such as electric beds, nebulizers, oxygen concentrators, air pumps for air mattresses and other medical equipment was tested and documented. New equipment incoming will be tested and documented as it arrives and repaired equipment will also be tested once repaired and documented. **2 How other residents having the potential to be affected by the same deficient practice** This alleged deficient practice has potential to affect all residents. **3 What measures will be put into place and what systemic changes will be made?** A monthly PCREE TELS task has been added as a reminder to test and document new equipment and repaired equipment under the equipment category. The new documentation will be added to the PCREE binder as new or repair items are tested.	06/27/2025

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	Based on record review on 05/05/25 at 1:00 p.m. with the Executive Director and Maintenance Director present, there was no documentation for the testing of PCREE, such as electric beds, nebulizers, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment. Based on interview at 1:00 p.m. during record review, the Executive Director said the facility had just become aware of the requirement and has not tested and documented the PCREE items yet. Based on observations between 2:00 p.m. and 5:00 p.m. during a tour of the facility with the Executive Director and Maintenance Director it was revealed the facility provided PCREE such as electric beds, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment was present in the facility. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		**4 How the corrective action will be monitored to ensure the deficient practice will not recur** Maintenance will report to QAPI no less than quarterly in perpetuity regarding life safety items. **5 By what date the systemic changes for each deficiency will be completed?** June 27, 2025	