STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING -- B. WING	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	333 W MISHAWAKA RD ELKHART, IN 46517

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/06/23 Facility Number: 000523 Provider Number: 155496 AIM Number: 100266930 At this Emergency Preparedness survey, Valley View Healthcare 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 94 certified beds. At the time of the survey, the census was 86. Quality Review completed on 04/11/23	E 0000		
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
David Eric Henke	Executive Director	04/27/2023

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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	Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to review and update the Emergency	E 0004	1. The Emergency Preparedness Plan, EPP, was	04/28/2023

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	Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 04/06/23 between 09:19 a.m. and 11:48 a.m., two copies of the EEP were provided that were located at the nurses station and Maintenance Directors office. Both copies had a review date of 2021 on the cover page, no other date could be found to show the EPP was reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director stated he was unaware if the EPP had been updated wtihin the last year. . This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		updated and reviewed by the Executive Director and the management team on 04/25/2023. The EPP books were update and replaced at the nursing station and maintenance office. The review document was signed by the Executive Director as an indication of review with the management team. 2. All residents had the potential to be affected. All EPP binders were reviewed and signed. 3. The review plan will coincide with the annual Emergency Drill through the Elkhart County Emergency Management System. The EPP will be reviewed for updates and changes and those changes provided to the management staff. The Executive Director will sign the book and managers will sign the inservice form. 4. The Executive Director/designee will review the binder annually for compliance. The review will be reviewed annually in accordance to regulations.	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b),			

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	§485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not			

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	limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.			
	Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 04/06/23 between 09:19 a.m. and 11:48 a.m., two copies of the EPP were provided that were located at the nurses station and in the Maintenance Director's office. Both copies had a review date of 2021 on the cover page, no other date could be found to show the EPP's Policies and Procedures were reviewed and updated within	E 0013	1. The Emergency Preparedness Plan, EPP, was updated and reviewed by the Executive Director and the management team on 04/25/2023. The review document was signed by the Executive Director as an indication of review with the management team. 2. All residents had the potential to be affected. All EPP binders were reviewed and signed. 3. The review plan will coincide with the annual Emergency Drill through the Elkhart County Emergency Management System. The EPP will be	04/28/2023

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	the last year. Based on an interview during records review, the Maintenance Director stated he was unaware if the copies of the EPP had been updated within the last year. . This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		reviewed for updates and changes and those changes are provided to the management staff. The Executive Director will sign the book and managers will sign the inservice form. 4. The Executive Director will review the binder with each change provided by the corporate compliance officer(s). The review will be reviewed annually in accordance to regulations.	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the failed to review and update the Emergency Preparedness Plan's (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include:	E 0029	1. The Emergency Preparedness Plan, EPP, was updated and reviewed by the Executive Director and the management team on 04/25/2023. The review document was signed by the Executive Director as an indication of the	04/28/2023

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	Based on records review with the Maintenance Director on 04/06/23 between 09:19 a.m. and 11:48 a.m., two copies of the EPP located at the nurses station and Maintenance Director's office had a review date of 2021 on the cover page, no other date could be found to show the EPP's Communication Plan was reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director stated he was unaware if the copies of the EPP had been updated within the last year. . This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		review with the management team. 2. All residents had the potential to be affected. All EPP binders were reviewed and signed. 3. The review plan will coincide with the annual Emergency Drill through the Elkhart County Emergency Management System. The EPP will be reviewed for updates and changes and those changes provided to the management staff. The Executive Director will sign the book and managers will sign the inservice form. 4. The Executive Director will review the binder with each change provided by the corporate compliance officer(s). The review will be reviewed annually in accordance to regulations.	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under			

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	485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training			

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	at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed reviewed and updated the Emergency Preparedness Plan's (EPP) Training and Testing Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 04/06/23 between 09:19 a.m. and 11:48 a.m., two copies of the EPP were provided from the nurses station and Maintenance Director's office had a review date of 2021 on the cover page, no other date could be found to show the EPP's Training and Testing Plan was reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director stated he was unaware if the copies of the EPP had been updated within the last year. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0036	1. The Emergency Preparedness Drill was practiced as a table top exercise on February 12/26/2022. The EPP was implemented regarding reporting and response. This incident was reviewed in a table top exercise as the facility's obligation for practice. This included review and signature page. 2. All resident had the potential to be affected. All EPP binders were reviewed and signed. 3. The facility is planning in cooperation with the Elkhart County Health Department to participate in a County Wide drill this summer/fall. The Elkhart County Health Department along with the Elkhart County Emergency Services will conduct Emergency Preparedness drills and Valley View healthcare is an active participant.	04/28/2023

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			4. The Executive Director or designee will attend the County Health Departments preparedness meetings and register Valley View Healthcare as active participants. Valley View is currently listed as a participant. All records of the preparedness meetings will be maintained in the master EPP binder.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing			

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	structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.			

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	(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance	E 0041	1. The Emergency Generator is self-tested weekly and monitored accordingly. Load testing is documented monthly. The weekly visual and load testing have commenced and will remain in compliance to regulation. 2. All resident had the potential to be affected. No other	04/28/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING -- B. WING	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	333 W MISHAWAKA RD ELKHART, IN 46517

(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
	Director on 04/06/23 between 09:19 a.m. and 11:48 a.m., the generator lacked monthly load testing and weekly visual testing required by LSC and NFPA 110. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned deficiency and stated the inspections should be in TELS, but documentation was unable to be located at the time of the survey. . The findings were reviewed with the Administrator and Maintenance Director at the exit conference.		emergencies occurred within the time period identified. 3. The facility does have an online prompt plan called TELS. The TELS program provides scheduled assignments that include weekly inspection and load testing verification. The Executive Director or designee or designee receive emailed messages of any schedule tasks that have not been completed in a timely manner. The Executive Director or Designee will immediately alert the Director of Maintenance when an alert email has messaged. 4. The Executive Director or Designee reviews tasks needing to be complete in the TELS system. The Executive Director will alert the Maintenance Director or designee to get an immediate action plan for the tasks needing to be completed. The Executive Director or Designee will monitor completed tasks 4 times per weeks for three weeks then 2 times per week for two weeks and then weekly thereafter to ensure compliance. This plan is reported in percent of tasks completed compared to those assigned. That percentage of completion will be reported to the QAPI team each month.	
K 0000 Bldg. 01				

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	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/06/23 Facility Number: 000523 Provider Number: 155496 AIM Number: 100266930 At this Life Safety Code survey, Valley View Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The 500, 600, and 700 Hall Units, which are in the southern portion of the facility, are decommissioned and do not have any residents living in them. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors, and 1 resident room. Battery operated smoke detectors are provided in 74 of 75 rooms resident rooms. The facility is fully protected by a 75 kW natural gas generator. The facility has a capacity of 94 beds dually certified for Medicare and Medicaid. At this survey the facility had a census of 86. All areas where residents have customary access were sprinklered. The facility has a detached garage providing storage of maintenance equipment and a shed containing storage of wheel chairs and walkers which were not sprinklered.	K 0000		

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	Quality Review completed on 04/11/23			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.			

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	18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 2 of 2 exit doors for the front entrance and exit gate were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. LSC 7.2.1.5.3 requires if provided, locks shall not	K 0222	1. The egress and non-egress doors of the facility are connected to the fire panel. In the event of an evacuation by emergency, the all EXIT doors unlock. In the event of electrical loss all EXIT doors disarm. The non-egressed doors at the front of the building and the rear gate now have the four digit code posted near the key pad. 2. All residents had the potential to be affected. No other	04/28/2023

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	require of a key, a tool, or special knowledge or effort for operation from the egress side This deficient practice could affect approximately 20 residents and staff. Findings include: Based on observation with the Maintenance Director on 04/06/23 between 11:52 a.m. and 1:45 p.m., the exit door for the front entrance and the emergency exit gate were marked as a facility exit, were magnetically locked, and could be opened by entering a four-digit code on the access control pad, but the code was not posted at both exits. Based on interview at the time of observation, the Maintenance Director agreed the codes to open the exit door were not posted by the access control pad. The findings were reviewed with Administrator and Maintenance Director during the exit conference. 3.1-19(b)		emergencies occurred within the time period identified. 3. The Maintenance Director will update the posted codes in the event of code changes on the front door and rear gate. The egress doors and non-egress doors are tested monthly for correct operation. These findings are posted in the TELS maintenance management system. Any door found to be out of compliance will be immediately addressed for corrective repair. 4. The Executive Director or designee twill be alerted of any nonfunctioning door or gate and will oversee the prompt repair or correction. The TELS report will be shared with the monthly QAPI team.	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on records review, observation, and interview, the facility failed to ensure 2 of 2 battery backup lights were tested monthly. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds and (5) Written records of visual inspections and tests shall be	K 0291	1. The fire emergency lights are inspected each month and logged in the TELS maintenance system application. The emergency lights in the electric transfer switch room and generator area were added to that monthly inspection list of emergency	04/28/2023

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	kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all building occupants when work is needed in the transfer switch room and/or generator during a power outage. Findings include: Based on an observation during a tour of the facility with the Maintenance Director on 04/06/23 between 11:52 a.m. and 1:45 p.m., there was a battery powered emergency light in the transfer switch room and anther one located next to the generator outside of the facility. Based on records review at 10:15 a.m., documentation of a monthly 30 second test for the battery powered emergency lights was not available for the months of June to December of 2022, as well as January through March of 2023. Based on an interview at the time of record review and observation, the Maintenance Director confirmed there are two battery powered lights in the facility with one being in the transfer switch room and the other at the generator. He further stated the documentation for the tests is most likely documented in the "Tels" electronic maintenance system, but being a new Maintenance Director, he does not have access to the "Tels" system. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		lighting locations. 2. All residents had the potential to be affected. 3. The Maintenance Director or designee will check each emergency light monthly and log the inspection on the TELS maintenance management system application. A copy of the test will be provided to the Executive Director or designee. 4. The monthly inspections are now logged in the TELS maintenance management system for the two locations specified. It is a scheduled task and any task found incomplete is automatically emailed to the Executive Director. Monthly documentation will be provided through the QAPI committee for 3 months until compliance is achieved.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance			

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	A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation on 04/06/23 between 11:52 a.m. and 1:45 p.m. with the Maintenance Director, the yellow trouble light on the main fire alarm control panel was illuminated stating that a trouble signal was sent for a smoke detector in zone 1, hall 7. Based on interview at the time of observation, the Maintenance Director confirmed that the yellow trouble light was illuminated due to a smoke detector malfunctioning and stated the alarm company was supposed to be fixing it this week. Findings were discussed with the Administrator and Maintenance Director at exit conference. 3.1-19(b)	K 0345	1. The smoke detectors are maintained by the maintenance department and the inspection/repairs are made with SafeCare Company. The 700 hall smoke detector was replaced by SafeCare and the system trouble light is off. 2. All residents had the potential to be affected. 3. The Maintenance Director or designee will check and test the smoke detectors monthly for all manual battery operated detectors and those with direct wire to the fire panel. Any system trouble light will be corrected by the Maintenance Director or designee. Any trouble in the system not able to be corrected by the Maintenance Director of Designee will be referred to SafeCare Company for immediate correction. 4. The monthly testing is now logged in the TELS maintenance management system. It is a scheduled task and any task found incomplete is automatically emailed to the Executive Director. The documentation checks will be provided to the QAPI committee	04/28/2023

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			each month for three months or until compliance is met.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 7.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1)	K 0353	1. The fire system gauges for wet fire systems are inspected monthly with dry system inspected weekly. The inspections are listed on the calendar of the TELS maintenance application. All testing of wet and dry systems are now documented and completed timely. 2. All residents had the potential to be affected. 3. The Maintenance Director or designee will check and test the fire system monthly and the dry fire system weekly. Any trouble or concern will be corrected by the	04/28/2023

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	shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 04/06/23 between 09:19 a.m. and 11:48 a.m., there was no weekly inspections of the dry pipe sprinkler system's gauges for the weeks past February 8, 2023 as well as missing weekly inspections for the month of January 2023. During an interview at the time of record review, the Maintenance Director stated inspections for the sprinkler gauges were documented in TELS and was unable to obtain reports due to not having been granted access to the software yet. Findings were discussed with the Administrator and Maintenance Director at exit conference. 3.1-19(b)		Maintenance Director or designee. Any trouble in the system not able to be corrected by the Maintenance Director of Designee will be referred to SafeCare Company for immediate correction. 4. The weekly testing of the dry system and the monthly testing of the wet fire system are now logged in the TELS maintenance management system. The Maintenance Director and assistant were educated on the required checks and documentation. It is a scheduled task and any task found incomplete is automatically emailed to the Executive Director. All test of smoke detectors will be reported through the QAPI system for three months or until 100% compliance is met.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to inspect 2 of 2 portable fire extinguishers in the laundry and dietary pantry were inspected each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states	K 0355	1. The fire extinguishers are inspected each month and logged in the TELS maintenance system application. The extinguishers located in the kitchen pantry and laundry area were added to that monthly inspection list of fire extinguisher locations.	04/28/2023

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	periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using pushto-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect approximately 15 staff and residents near the laundry area and dietary pantry. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 04/06/23 between 11:52 a.m. and 1:45 p.m., an ABC extinguisher located in the laundry area were missing monthly inspections past August 2022.		2. All residents had the potential to be affected. 3. The Maintenance Director or designee will check each fire extinguisher monthly and log the inspection on the TELS maintenance management system application. 4. The monthly inspections are now logged in the TELS maintenance management system for the two locations specified. It is a scheduled task and any task found incomplete is automatically emailed to the Executive Director. Documentation of inspection of extinguishers will be reported through the QAPI system each month for three months or until 100%.	

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	Furthermore, an ABC extinguisher located in the dietary pantry was also missing monthly inspection past August 2022. Based on interview at the time of observations, the Maintenance Director confirmed the two extinguishers located in the two locations were missing monthly inspections. Findings were discussed with the Administrator and Maintenance Director at exit conference. 3.1-19(b)			
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of			

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	unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 12 resident room corridor doors on the 300 wing was provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect approximately 2 residents in room 311. Findings include: Based on observation with the Maintenance Director and on 04/06/23 between 11:52 a.m. and 1:45 p.m., the corridor door to resident room 311 did not latch into the frame when tested three times. Based on interview at the time of observation, the Maintenance Director agreed the corridor door would not latch into the door frame and needed adjustment. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0363	1. The hardware on the door for room 311 was adjusted to allow for complete and timely closure. Doors are inspected monthly for closure testing and are a part of the scheduled tasks on TELS maintenance management system application. 2. Two residents had the potential to be affected. 3. The Maintenance Director or designee will check ten random doors monthly and log the inspection on the TELS maintenance management system application. Any door that does not latch according to accepted standards will be immediately addressed by the maintenance department or outside contractor. 4. The monthly inspections are logged in the TELS maintenance management system. It is a scheduled task and is trackable in	04/28/2023

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VALLEY VIEW HEALTHCARE CENTER	333 W MISHAWAKA RD ELKHART, IN 46517

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			the TELS maintenance system application. All door inspection documents will be provided to the QAPI committee each month for three months or until 100% compliance is met.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview; the facility	K 0741	1. Smoking at this facility is	04/28/2023

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	failed to ensure smoking was only conducted in designated areas and were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect approximately 10 staff and residents near the kitchen Findings include: Based on observation during a tour of the facility with the Maintenance Director on 04/06/23 between 11:52 a.m. and 1:45 p.m., a "No Smoking sign" was located outside of the emergency exit leading from the kitchen. Approximately over 30 cigarette butts were disposed on the ground around the area. Based on interview at the time of observations, the Maintenance Director agree there were cigarette butts on the ground in the aforementioned location. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		permissible in certain areas. Butt cans have been placed in the affected area to contain cigarette butts in that area. Four butt cans have been purchased and placed. 2. Up to ten employees had the potential to be affected. 3. The Maintenance Director or designee will check the exterior each week and include the search for cigarette butts on the ground. Education of affected staff has been completed per telephone application and will again occur with any findings of cigarette butts on the ground. Further corrective steps may be taken as indicated including progressive discipline to those outside of the policy. 4. The weekly inspections are logged in the TELS maintenance management system. It is a scheduled task and is trackable in the TELS maintenance system application. Any cigarette butts found on the ground will be logged and the information sent through the QAPA meeting for three months or until 100% compliance is met.	
K 0761 SS=F Bldg. 01	Based on record review and interview, the facility failed to ensure annual inspection and testing of all the fire door assemblies in the facility were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in	K 0761	1. The self-closing fire doors of the facility are connected to the fire panel. In the event of a fire emergency, the fire doors release and close. The doors are tested at a minimum of annually to	04/28/2023

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	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 door when it is in the closed position. (9) Auxiliary hardware items that interfere or		ensure correct closure and latching of the fire doors per NFPA 80.5.2.1. 2. All residents had the potential to be affected. T 3. The Maintenance Director will ensure the fire doors and door mechanisms are inspected according to code no less than annually. The inspections are posted in the TELS maintenance management system. Any door found to be out of compliance will be immediately addressed for corrective repair. 4. The TELS Maintenance system application alerts the Executive Director or designee of any missed tasks including the fire door and latching mechanism inspections. The Maintenance Director will inspect the doors and latch mechanisms ever three months for the first quarter and then each six months for one year. Thereafter the fire doors and latching mechanisms will be inspected annually based on 100% compliance.	

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	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. Findings include: Based on record review with the Maintenance Director on 04/06/23 between 09:19 a.m. and 11:48 a.m., no documentation of an annual inspection for all fire door assemblies were available for review. Based on interview at the time of record review, the Maintenance Director stated that fire door inspections should have been conducted, but was unaware if they had been completed within the last year. Findings were discussed with the Administrator and Maintenance Director at exit conference.			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised			

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	once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 facility's diesel powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on records review with the Maintenance	K 0918	1. The Emergency Generator is self-tested weekly and monitored accordingly. The annual inspection of fuel quality was added to the contractor's obligation however **the fuel is natural gas and cannot be tested.** The documentation of generator weekly and monthly inspections are now documented in TELS. 2. All resident had the potential to be affected. **The fuel testing is not complete as the generator is a natural gas system** 3. The facility does have an annual contract with SafeCare Company to inspect and service	04/28/2023

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	Director on 04/06/23 between 09:19 a.m. and 11:48 a.m., no documentation of an annual fuel quality test for the diesel generator within the past year was available for review. Based on interview at the time of records review, the Maintenance Director stated the facility does have a diesel generator but could not find documentation whether a test had been done within the past year. This finding was reviewed with the Administrator, and Maintenance Director at the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 28 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to 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 records review with the Maintenance Director on 04/06/23 between 09:19 a.m. and 11:48 a.m., documentation for weekly generator inspections were not located for the following dates: a) October 2022 through March of 2023 b) June 2022 through September 2022		the Emergency generator. . That documentation for weekly and monthly testing will be uploaded into the TELS maintenance application and a hard copy help by the Maintenance Director or designee. 4. The Executive Director or designee to get an immediate action plan for the task needing to be completed by the TELS alert application. All documentation will be provided to the QAPI committee each month for three months or until 100% compliance is met.	

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	Based on interview at the time of record review, the Maintenance Director stated that the generator checks are filled out on TELS, but they were unable to access the reports due to being a new employee and has not been granted access to view the records. Findings were discussed with the Administrator and Maintenance Director at exit conference. 3. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 3 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 04/06/23 between 09:19 a.m. and 11:48 a.m., no documentation for the months of June and July of 2022 as well as the months between October 2022 through March of 2023 to show the diesel generator set in service was exercised under load at least once monthly, for a minimum of 30 minutes. Based on an interview at the time of records review, the Maintenance Director stated the inspections were submitted into the TELS			

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	program but was unable to gain access due to being recently hired and unable to access any inspection reports. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			