STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155274	A. BUILDING -- B. WING	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF ROCKPORT SKILLED NURSING FACILITY, THE	815 W WASHINGTON ST ROCKPORT, IN 47635

(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: 06/17/25 Facility Number: 000174 Provider Number: 155274 AIM Number: 100274810 At this Emergency Preparedness survey, The Waters of Rockport Skilled Nursing Facility was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 60 certified beds. At the time of the survey, the census was 34. Quality Review completed on 06/24/25 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements.	
E 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 exercise 1 of 1 emergency	E 0041	It is the intent of the facility to ensure to implement the emergency power system inspection, testing and maintenance requirements found in the healthcare facilities code, NFPA 110, and life safety code in accordance with 42 CFR 483.73 (e) (2) and to ensure to exercise	07/10/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Natalie Walker	HFA	07/04/2025

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	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 residents, staff, and visitors. Findings include: Based on record review on 06/17/25 at 1:15 p.m. with the Administrator and Maintenance Director present, the monthly load percentage for the diesel powered generator was documented less than 30% during all of the past 12 months. Based on interview at the time of record review, the Maintenance Director acknowledged the generator ran under load on a monthly basis but does not achieve 30% of the name plate rating each month. Additionally, the Maintenance Director acknowledged a load bank test for the generator has not occurred within the past 12		emergency generator annually and to ensure emergency generator is provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses station to meet set standards. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 7/2/2025 the maintenance supervisor/licensed generator contractor/designee completed the required load testing to meet set standards. The administrator verified the work on 7/3/2025. On 7/8/2025 the licensed generator contractor will move the remote generator annunciator panel to the east nurses station to meet set standards. The administrator will verify the work on 7/8/2025. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents, staff and visitors have the potential to be affected but none were. **What measures will be put into place and what systemic changes will be made to**	

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	month period. It could not be determined when the most recent load bank test for the generator was performed. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' stations. NFPA 99, 2012 Edition, Health Care Facilities Code, at 6.4.1.1.17 requires a remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate: a. When the emergency or auxiliary power source is operating to supply power to load. b. When the battery charger is malfunctioning. (2) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: a. Low lubricating oil pressure. b. Low water temperature. c. Excessive water temperature. d. Low fuel when the main fuel storage tank contains less than a 4-hour operating supply. e. Overcrank (failed to start). f. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This		**ensure that the deficient practice does not recur?** On 7/2/2025 the administrator inserviced the maintenance supervisor/all staff/designee on the requirement to ensure the generator's monthly load testing obtains at least 30% of the name plate rating or load bank testing is completed and to ensure the remote generator annunciator panel is at a supervised nurses station to meet set standards. The maintenance supervisor/designee will ensure the generator's monthly load testing obtains at least 30% of the name plate rating or load bank testing is completed and to ensure the remote generator annunciator panel is at a supervised nurses station as part of the facility's monthly preventative maintenance program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The maintenance supervisor/designee will review with the administrator the inspection results. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The administrator and maintenance supervisor/designee	

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	derangement signal shall activate when any of the conditions in 6.4.1.1.17(1) and (2) occur but need not display these conditions individually. This deficient practice could affect all residents, as well as visitors and staff in the facility. Findings include: Based on observation on 06/17/25 at 1:50 p.m. during a tour of the facility with the Administrator and Maintenance Director, the remote generator annunciator panel was located at the West Nurse's Station which was not currently in operation. When asked, the Administrator said the West Nurse's Station is currently closed due to a low census. There are no residents currently on the West Unit and the nearest Nurse's Station is located on the other side of the facility on the East Unit. The generator annunciator panel would not be heard from the East Unit if activated. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		will review the emergency preparedness policy manual and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The administrator will present the results at the QAPI meeting. Results and system components will be reviewed by the QAPI committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **By what date the systemic changes for each deficiency will be completed?** 7/10/2025	
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: 06/17/25 Facility Number: 000174 Provider Number: 155274 AIM Number: 100274810 At this Life Safety Code survey, The Waters of	K 0000	Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of	

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	Rockport Skilled Nursing Facility 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 (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 60 and had a census of 34 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered, except two detached structures, a wood framed garage used for a maintenance shop and facility storage, as well as a wood framed house used for facility storage. Quality Review completed on 06/24/25		correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements.	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Based on record review and interview, the facility failed to ensure the preventative maintenance for all battery operated smoke alarms in resident rooms was conducted according to manufacturer's published instructions. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the	K 0300	It is the intent of the facility to ensure the preventative maintenance for all battery operated smoke alarms in resident rooms is conducted according to manufacturer's published instructions to meet set standards. **What corrective action(s) will**	07/10/2025

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	manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents. Findings include: Based on record review on 06/17/25 at 12:00 p.m. with the Administrator and Maintenance Director present, the "Battery Operated Smoke Detectors Maintenance Log" showed monthly testing of the battery operated smoke alarms. The manufacturer's published instructions on the back side of each smoke alarm stated the alarms require weekly testing. Based on interview at 12:00 p.m., the Maintenance Director stated the smoke alarms are tested monthly, and agreed the alarms should be tested weekly according to manufacturer's published instructions. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**be accomplished for those residents found to have been affected by the deficient practice?** On 7/1/2025 the maintenance supervisor/designee checked and inspected per manufacturer's guidelines, weekly, all the battery operated smoke alarms to meet set standards. Administrator verified work on 7/2/2025. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents, visitors, and staff have the potential to be affected but none were. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** On 7/2/2025 the administrator inserviced the maintenance supervisor/designee on the requirements to ensure all battery operated smoke alarms are maintained per manufacturer's guidelines and testing is conducted on a weekly basis to meet set standards. The maintenance supervisor/designee will ensure all battery operated smoke alarms are maintained and testing is conducted weekly per	

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			manufacturer's guidelines and will document the results on the battery operated smoke detector maintenance log to be filed in the life safety binder as part of the facility's preventive maintenance program. If any issues are discovered, they will be addressed and resolved immediately. The maintenance supervisor/designee will review with the administrator the inspection results. The administrator will monitor adherence to the preventative maintenance schedule and validate the preventative maintenance documentation is in place. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The inspection results will be presented by the maintenance supervisor/designee to the administrator monthly and the administrator will present the inspection results at the monthly QAPI meeting. Inspection results and system components will be reviewed by the QAPI committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	

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			By what date the systemic changes for each deficiency will be completed? 7/10/2025	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as a Laundry room door, would close completely and latch automatically into its frame. This deficient practice could affect over 10 residents, staff and visitors. Findings include: Based on observation on 06/17/25 at 12:52 p.m. during a tour of the facility with the Administrator and Maintenance Director, the Laundry room corridor door, which opens into the corridor next to the north center exit door, did not close completely and latch automatically when tested several times. Based on interview at 12:52 p.m., the Maintenance Director acknowledged the Laundry room door did not close completely and latch automatically and said he would fix it as soon as possible. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0321	It is the intent of the facility to ensure hazardous area doors, such as laundry room doors, will completely close and latch automatically into the frame to meet set standards. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 7/2/2025 the maintenance director/designee repaired the laundry room door to ensure it self closes and latches into its frame to meet set standards. Administrator verified work on 7/2/2025. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents, staff and visitors have the potential to be affected but none were. **What measures will be put into place and what systemic**	07/10/2025

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			changes will be made to ensure that the deficient practice does not recur? On 7/2/2025 the administrator inserviced the maintenance supervisor/designee/all staff on the requirement to ensure hazardous area doors are provided with self closing devices and latch into their frame to meet set standards. The maintenance supervisor/designee will ensure hazardous areas are provided with self closing devices and latch into the frame as part of the facility's monthly preventative maintenance program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The maintenance supervisor/designee will review with the administrator the inspection results. The administrator will monitor adherence to the preventative maintenance schedule and validate the preventative maintenance documentation is in place. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The inspection results will be presented by the maintenance director/designee to the	

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			administrator monthly and the administrator will present the inspection results at the monthly QAPI meeting. Inspection results and system components will be reviewed by the QAPI committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **By what date the systemic changes for each deficiency will be completed?** 7/10/2025	
K 0324 SS=C Bldg. 01	NFPA 101 Cooking Facilities Based on record review and interview, the facility failed to ensure there was documentation available to show 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the	K 0324	It is the intent of the facility to ensure documentation is available to show kitchen exhaust systems are inspected semiannually to meet set standards. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 7/2/2025 the maintenance supervisor/designee ensured semiannual inspections for the range hood exhaust system are done every 6 months and are documented to meet set standards. The administrator verified work on 7/2/2025.	07/10/2025

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	authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect kitchen staff and residents, staff, and visitors while in the main dining room. Findings include: Based on record review on 06/17/25 at 11:50 a.m. with the Administrator and Maintenance Director present, there were two semi annual inspection reports available for review during the past twelve months for the range hood exhaust system, however, the inspections were almost nine months apart, 08/15/24 and 05/04/25. Based on interview at the time of record review, the Maintenance Director said he started work at the facility in April and noticed the vendor was late for the February 2025 inspection. So he called the vendor and was able to get the vendor to the facility in May 2025. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents, staff and visitors have the potential to be affected but none were. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** On 7/2/2025 the administrator inserviced the maintenance supervisor/dietary manager/designee to ensure to maintain the range hood exhaust system and ensure the semiannual inspection is conducted every 6 months to meet set standards. The maintenance supervisor and dietary manager will ensure to maintain the range hood exhaust system and ensure the semiannual inspections are conducted every 6 months as a part of the facility's semiannual preventive maintenance program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The maintenance supervisor/designee will review with the administrator the results of the inspection.	

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			The administrator will monitor the adherence to the preventive maintenance schedule and validate the preventive maintenance documentation is in place. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The monitoring results will be presented by the administrator at the monthly QAPI meeting. Inspection results and system components will be reviewed by the QAPI committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **By what date the systemic changes for each deficiency will be completed?** 7/10/2025	
K 0345 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having	K 0345	It is the intent of the facility to ensure to maintain the fire alarm systems in accordance with NFPA 72, as required by LSC 101 sections 19.3.4.5.1 and 9.1 to meet set standards. **What corrective action(s) will**	07/10/2025

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	jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect mostly laundry staff, plus any residents within the adjacent smoke compartment. Findings include: Based on observations on 06/17/25 at 12:50 p.m. during a tour of the facility with the Administrator and Maintenance Director, there was a ceiling mounted heat detector in the laundry room hanging loosely from its wires and not secured to the ceiling. Based on interview at 12:50 p.m., the Maintenance Director acknowledged the heat detector not being flush with the ceiling and said he would correct it as soon as possible. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**be accomplished for those residents found to have been affected by the deficient practice?** On 7/2/2025 the maintenance supervisor/designee repaired the ceiling mounted heat detector in the laundry room to ensure it is secured to the ceiling to meet se4t standards. The administrator verified the work on 7/2/2025. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents, staff and visitors have the potential to be affected but none were. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** On 7/2/2025 the administrator inserviced the maintenance supervisor/designee on the requirement to ensure to maintain the fire alarm systems including ensuring ceiling mounted heat detectors are secured to the ceiling to meet set standards. Maintenance supervisor/licensed fire alarm contractor/designee will ensure to maintain the fire alarm systems including ensuring ceiling mounted heat detectors are secured to the ceiling as part of	

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			the facility's monthly preventive maintenance program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The maintenance supervisor/designee will review with the administrator the inspection results. The administrator will monitor adherence to the preventative maintenance schedule and validate the preventative maintenance documentation is in place. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The inspection results will be presented by the maintenance director/designee to the administrator and the administrator will present the inspection results at the monthly QAPI meeting. Inspection results and system components will be reviewed by the QAPI committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **By what date the systemic changes for each deficiency will be completed?**	

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K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on observation and interview, the facility failed to ensure a sprinkler head in 1 of 7 smoke compartments covered with a foreign material was 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 mostly kitchen staff, plus all residents while in the adjacent dining room. Findings include: Based on observation on 06/17/25 at 2:02 p.m. during a tour of the facility with the Administrator and Maintenance Director, there was one pendent sprinkler head in the kitchen directly over the steam table and in front of the stove that was covered with what appeared to be grease build up and dust/dirt. This was confirmed by the Maintenance Director at 2:02 p.m. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0353	7/10/2025 It is the intent of the facility to ensure sprinkler heads in smoke compartments covered with a foreign material are replaced and to ensure sprinkler system gauges on the sprinkler system riser are replaced every 5 years or documented and tested every 5 years by comparison with a calibrated gauge and to ensure the ceiling in sprinklered smoke compartments are maintained to allow sprinkler heads to function to their full capability to meet set standards. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** on 7/2/2025 the maintenance supervisor/sprinkler contractor/designee repaired the sprinkler head in the kitchen directly over the steam table to meet set standards. The administrator verified the work on 7/2/2025. On 7/2/2025 the maintenance supervisor/sprinkler contractor/designee replaced four sprinkler gauges on the sprinkler system riser to meet set standards. The administrator	07/10/2025

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	2. Based on observation and interview, the facility failed to ensure 4 of 4 sprinkler system gauges on the sprinkler system riser were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observation on 06/17/25 at 1:00 p.m. during a tour of the facility with the Administrator and Maintenance Director, all four sprinkler gauges on the sprinkler system riser had dates of 2019 which were past due for replacement or recalibration. No recalibration date information was affixed to the sprinkler system gauges. Based on interview at 1:00 p.m., the Maintenance Director confirmed the sprinkler system gauges had not been recalibrated within the most recent five year period and would have the gauges replaced as soon as possible. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure the ceiling in 1 of 7 sprinklered smoke compartments was maintained to allow sprinkler heads to function to their full		verified the work on 7/2/2025. On 7/2/2025 the maintenance supervisor/designee repaired the two holes in the damaged ceiling with one hour fire rated material in the boiler room to meet set standards. The administrator verified the work on 7/3/2025. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents, staff and visitors have the potential to be affected but none were. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** On 7/2/2025 the administrator inserviced the maintenance supervisor/designee on the requirement to ensure to maintain the sprinkler system and ensure sprinkler heads are not covered with dust/dirt, ensuring sprinkler gauges on the riser are recalibrated or replaced every 5 years and to ensure there are no penetrations or damaged ceilings to meet set standards. The maintenance supervisor/designee will ensure to maintain the sprinkler system and ensure sprinkler heads are not	

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	capability. This deficient practice could affect over 10 residents in the same smoke compartment. Findings include: Based on observation on 06/17/25 at 12:45 p.m. during a tour of the facility with the Administrator and Maintenance Director, there were two holes of at least six inches by six inches and a damaged ceiling with spaces between the drywall sections in the Boiler Room. Based on interview at 12:45 p.m., the Maintenance Director acknowledged the damaged ceiling within the Boiler Room and agreed it will need to be repaired. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		covered by dust/dirt, ensure sprinkler gauges on the riser are recalibrated or replaced every 5 years , and ensure there are no penetrations or damaged ceilings as part of the facility's annual preventive maintenance program and document the inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The maintenance supervisor/designee will review with the administrator the inspection results. The administrator will monitor adherence to the preventative maintenance schedule and validate the preventative maintenance documentation is in place. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The inspection results will be presented by the maintenance supervisor/designee to the administrator monthly and the administrator will present the inspection results at the monthly QAPI meeting. Inspection results and system components will be reviewed by the QAPI committee with subsequent plans of correction developed and implemented as deemed	

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			necessary to ensure compliance is maintained. **By what date the systemic changes for each deficiency will be completed?** 7/10/2025	
K 0374 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 2 of 6 sets of smoke/fire barrier doors would close completely to form a smoke resistant barrier. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on observations on 06/17/25 during a tour of the facility with the Administrator and Maintenance Director, the following was noted: a. At 1:40 p.m., the set of smoke barrier doors near rooms 107 and 108 did not close completely when tested several times. There was a half inch gap between the doors when closed fully. b. At 2:40 p.m. the set of smoke barrier doors near rooms 8 and 9 did not close completely when tested several times. The west side door would not close on its own when released from the magnetic holder. The bottom of the door drug for at least eight inches on the floor before it finally closed on its own. It had to be manually closed due to it dragging on the floor. This was	K 0374	It is the intent of the facility to ensure sets of smoke/fire barrier doors will close completely to form a smoke resistant barrier to meet set standards. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 6/30/2025 the maintenance supervisor/designee repaired the set of smoke barrier doors near rooms 107 and 108 to ensure they close completely and installed a fire rated seal to ensure there are no gaps when the door is fully closed. The maintenance supervisor/designee also repaired the set of smoke barrier doors near rooms 8 and 9 to ensure they close properly to meet set standards. The administrator verified this work on 6/30/2025. **How other residents having the potential to be affected by the same deficient practice will be**	07/10/2025

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	acknowledged by the Maintenance Director at 2:40 p.m. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**identified and what corrective action(s) will be taken?** All residents, staff and visitors have the potential to be affected but none were. On 7/2/2025 the maintenance director/designee inspected all smoke barrier doors throughout the facility and found no other negative findings. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** On 7/2/2025 the administrator inserviced the maintenance supervisor/designee and all staff on the requirements that smoke barrier doors must close completely to meet set standards. Maintenance director/designee will inspect all smoke barrier doors throughout the facility monthly to ensure they close completely as part of the facility's preventative maintenance program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The maintenance supervisor/designee will review with the administrator the inspection results. The administrator will monitor adherence to the preventive maintenance schedule and validate the preventative maintenance documentation is in place.	

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The inspection results will be presented by the maintenance supervisor/designee to the administrator monthly and the administrator will present the inspection results at the monthly QAPI meeting. Inspection results and system components will be reviewed by the QAPI committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **By what date the systemic changes for each deficiency will be completed?** 7/10/2025	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to ensure 8 of 12 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents.	K 0712	It is the intent of the facility to ensure fire drills include the verification of transmission of the fire alarm signal to the monitoring station to meet set standards. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	07/10/2025

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	Findings include: Based on review of the facility's fire drill reports on 06/17/25 at 10:50 a.m. with the Administrator and Maintenance Director present, 8 of 12 fire drill reports performed during the past 12 month period were not provided with documentation for the transmission of the alarm to the monitoring company. Based on interview at the time of record review, the Maintenance Director confirmed there was no information included with 8 of 12 fire drill reports to verify that transmission of the alarm was received by the monitoring company. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3-1.19(b) 3.1-51(c)		**practice?** On 7/7/2025 the maintenance director will conduct a fire drill on all 3 shifts at varying times and will include the transmission of the alarm to the monitoring company and documented results on the fire drill log sheet in the facility's life safety binder to meet set standards. The administrator will verify the work on 7/7/2025. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents, staff and visitors have the potential to be affected but none were. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** On 7/2/2025 the administrator inserviced the maintenance supervisor on the requirement to ensure fire drills have complete documentation including the transmission of the fire alarm signal to the monitoring company to meet set standards. The maintenance supervisor/administrator/designee will ensure fire drills have complete documentation including the transmission of the fire alarm signal to the monitoring company	

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			as part of the facility's monthly preventative maintenance program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The maintenance supervisor/designee will review with the administrator the inspection results. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The fire drill documentation will be presented by the maintenance supervisor/designee to the administrator and the administrator will present the inspection results at the monthly QAPI meeting. Inspection results and system components will be reviewed by the QAPI committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **By what date the systemic changes for each deficiency will be completed?** 7/10/2025	
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors			

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	Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 1 of 1 oxygen room fire door assembly 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 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.	K 0761	It is the intent of the facility to ensure an annual inspection and testing of oxygen room fire door assemblies are completed in accordance with LSC 19.1.1.4.1.1 to meet set standards. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 7/2/2025 the maintenance supervisor conducted the annual inspection of the oxygen transfilling room fire door assembly and documented the results in the life safety binder to meet set standards. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents, staff and visitors have the potential to be affected but none were. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** On 7/2/2025 the administrator inserviced the maintenance supervisor to ensure an annual inspection for the fire doors is completed including the oxygen transfilling room fire door and	07/10/2025

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	(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 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 mostly staff because the West Unit is currently closed to residents, except 1 or 2 residents while using the Therapy gym. Findings include: Based on record review on 06/17/25 at 12:15 p.m. with the Administrator and Maintenance Director present, the facility was unable to provide documentation for an annual inspection of the oxygen transfilling room fire door assembly for the past 12 month period or prior. Based on interview at the time of record review, the Maintenance Director said there was no documentation of an annual inspection of the oxygen transfilling room fire door assembly available to review for the past 12 month period. Based on observations during a tour of the facility between 12:40 p.m. and 3:15 p.m., there was one oxygen transfilling room fire door assembly noted in the facility. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		documented to meet set standards. The maintenance supervisor/designee will ensure an annual inspection of the fire doors is completed and documented as part of the facility's annual preventive maintenance program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The maintenance supervisor/designee will review with the administrator the inspection results. The administrator will monitor adherence to the preventative maintenance schedule and validate the preventative maintenance documentation is in place. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The inspection results will be presented by the maintenance supervisor/designee to the administrator monthly and the administrator will present the inspection results at the monthly QAPI meeting. Inspection results and system components will be reviewed by the QAPI committee with subsequent plans of correction developed and implemented as deemed	

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	3.1-19(b)		necessary to ensure compliance is maintained. **By what date the systemic changes for each deficiency will be completed?** 7/10/2025	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Based on observation, record review, and interview, the facility failed to ensure complete documentation was available for all nonhospital-grade electrical receptacles in all resident room locations tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on record review on 06/17/25 at 12:30 p.m. with the Administrator and Maintenance Director present, there was some documentation available	K 0914	It is the intent of the facility to ensure complete documentation for all non-hospital grade electrical receptacles in all resident room locations are tested at least annually to meet set standards. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 7/3/2025 the maintenance supervisor/designee completed the annual resident room receptacle testing including itemizing the room location and the receptacle locations in each room to meet set standards. The administrator verified the work on 7/4/2025. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents, staff and visitors have the potential to be affected but none were.	07/10/2025

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	of an annual resident room receptacle test for non hospital-grade receptacles for the past 12 month period, however, the documentation only included 18 of the 45 resident room receptacle tests. Based on interview at the time of record review, the Maintenance Director said electrical receptacles in resident rooms were not hospital-grade receptacles as far as he knew. The Maintenance Director said he could not find any more documentation to show that annual testing per NFPA 99, Receptacle Testing requirements was met with all pertinent information within the past 12 month period for the remaining 27 resident room receptacles. Based on observations between 12:40 p.m. and 3:15 p.m. during a tour of the facility with the Administrator and Maintenance Director, there were at least four to six electrical receptacles in each resident room. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** On 7/2/2025 the administrator inserviced the maintenance director/designee on the requirement to ensure the annual resident room receptacle testing is completed to meet set standards. Maintenance supervisor/designee will ensure the annual resident room receptacle testing is completed and documented as part of the facility's annual preventive maintenance program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The maintenance supervisor/designee will review with the administrator the inspection results. The administrator will monitor adherence to the preventative maintenance schedule and validate the preventative maintenance documentation is in place. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The inspection results will be	

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			presented by the maintenance supervisor/designee to the administrator monthly and the administrator will present the inspection results at the monthly QAPI meeting. Inspection results and system components will be reviewed by the QAPI committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **By what date the systemic changes for each deficiency will be completed?** 7/10/2025	
K 0916 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' stations. NFPA 99, 2012 Edition, Health Care Facilities Code, at 6.4.1.1.17 requires a remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate: a. When the emergency or auxiliary power source is operating to supply power to load. b. When the battery charger is malfunctioning. (2) Individual visual signals plus a common	K 0916	It is the intent of the facility to ensure emergency generator is provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station, such as a nurses station, to meet set standards. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 7/8/2025 the licensed generator contractor will move the remote generator annunciator panel to the supervised east unit nurses station to meet set	07/10/2025

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	audible signal to warn of an engine-generator alarm condition shall indicate: a. Low lubricating oil pressure. b. Low water temperature. c. Excessive water temperature. d. Low fuel when the main fuel storage tank contains less than a 4-hour operating supply. e. Overcrank (failed to start). f. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 6.4.1.1.17(1) and (2) occur but need not display these conditions individually. This deficient practice could affect all residents, as well as visitors and staff in the facility. Findings include: Based on observation on 06/17/25 at 1:50 p.m. during a tour of the facility with the Administrator and Maintenance Director, the remote generator annunciator panel was located at the West Nurse's Station which was not currently in operation. When asked, the Administrator said the West Nurse's Station is currently closed due to a low census. There are no residents currently on the West Unit and the nearest Nurse's Station is located on the other side of the facility on the East Unit. The generator annunciator panel would not be heard from the East Unit if activated. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		standards. The administrator will verify the work on 7/8/2025. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents, staff and visitors have the potential to be affected but none were. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** On 7/2/2025 the administrator inserviced the maintenance supervisor and all staff on the requirement to ensure generator annunciator panels are in proper operating conditions to meet set standards. The maintenance director will ensure generator annunciator panels are in proper operating condition as part of the facility's weekly preventive maintenance program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The maintenance supervisor/designee will review with the administrator the inspection results. The administrator will monitor adherence to the preventative maintenance schedule and	

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			validate the preventive maintenance documentation is in place. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The inspection results will be presented by the maintenance supervisor/designee to the administrator monthly and the administrator will present the inspection results at the monthly QAPI meeting. Inspection results and system components will be reviewed by the QAPI committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **By what date the systemic changes for each deficiency will be completed?** 7/10/2025	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to exercise 1 of 1 emergency 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	K 0918	It is the intent of the facility to ensure to exercise emergency generator annually to meet the requirements of NFPA 110, 2010 edition, the standard for emergency and standby powers systems, chapter 8.4.2 to meet	07/10/2025

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	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 residents, staff, and visitors. Findings include: Based on record review on 06/17/25 at 1:15 p.m. with the Administrator and Maintenance Director present, the monthly load percentage for the diesel powered generator was documented less than 30% during all of the past 12 months. Based on interview at the time of record review, the Maintenance Director acknowledged the generator ran under load on a monthly basis but does not achieve 30% of the name plate rating each month. Additionally, the Maintenance Director acknowledged a load bank test for the generator has not occurred within the past 12 month period. It could not be determined when the most recent load bank test for the generator was performed. This finding was reviewed with the Administrator		set standards. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 7/3/2025 the maintenance supervisor/licensed generator contractor/designee completed the required load testing to meet set standards. The administrator verified the work on 7/3/2025. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents, staff and visitors have the potential to be affected but none were. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** On 7/2/2025 the administrator inserviced the maintenance supervisor/designee on the requirement to ensure the generator's monthly load testing obtains at least 30% of the name plate rating to meet set standards. The maintenance supervisor will ensure the generator's monthly load testing obtains at least 30% of the name plate rating as part of the facility's preventive	

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	and Maintenance Director during the exit conference. 3.1-19(b)		maintenance program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The maintenance supervisor/designee will review with the administrator the results of the inspection. The administrator will monitor adherence to the preventative maintenance schedule and validate the preventative maintenance documentation is in place. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The inspection results will be presented by the maintenance director/designee to the administrator monthly and the administrator will present the results of the inspections at the monthly QAPI meeting. Inspection results and system components will be reviewed by the QAPI committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **By what date the systemic changes for each deficiency will be completed?** 7/10/2025	

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K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure power strips were not used as a substitute for fixed wiring in 2 of 45 resident rooms. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect four residents. Findings include: Based on observations on 06/17/25 during a tour of the facility with the Administrator and Maintenance Director, the following was noted: a. At 2:10 p.m. resident room 14 had one unapproved power strip with a TV and phone charger plugged in, furthermore, there was a small refrigerator plugged into another power strip. This was acknowledged by the Maintenance Director at 2:10 p.m. b. At 2:14 p.m. resident room 12 had a small refrigerator plugged into a power strip. This was acknowledged by the Maintenance Director at 2:14 p.m. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0920	It is the intent of the facility to ensure power strips are not used as a substitute for fixed wiring in resident rooms to meet set standards. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 6/30/2025 the maintenance supervisor/designee removed the power strips from resident rooms 14 and 12 to meet set standards. Administrator verified the work on 6/30/2025. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents, staff and visitors have the potential to be affected but none were. On 6/30/2025 the maintenance supervisor/designee inspected all rooms throughout the facility for power strips and found no additional negative findings. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**	07/10/2025

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			On 7/2/2025 the administrator inserviced the maintenance supervisor/designee/all other staff that power strips are not to be used as a substitute for fixed wiring to meet set standards. The maintenance supervisor/designee will inspect all rooms throughout the facility on a monthly basis to ensure they do not have power strips in use as part of the facility's preventative maintenance program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The maintenance supervisor/designee will review with the administrator the inspection results. The administrator will monitor adherence to the preventative maintenance schedule and validate the preventative maintenance documentation is in place. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The inspection results will be presented by the maintenance director/designee to the administrator monthly and the administrator will present the inspection results at the monthly QAPI meeting. Inspection results	

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			and system components will be reviewed by the QAPI committee with subsequent plans of corrections developed and implemented as deemed necessary to ensure compliance is maintained. **By what date the systemic changes for each deficiency will be completed?** 7/10/2025	
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	K 0921	It is the intent of the facility to conduct the required maintenance and maintain complete documentation of inspection for patient care related electrical equipment to meet set standards. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 7/8/2025 the facility's trained regional property manager will conduct PCREE testing on PCREE in the facility including electric beds, nebulizers, oxygen concentrators, vital sign machines, and other electrical medical equipment to meet standards. The administrator will verify the work on 7/8/2025. **How other residents having the**	07/10/2025

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	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: Based on record review on 06/17/25 at 11:10 a.m. with the Administrator 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 11:10 a.m. during record review, the Administrator said she just found out about the requirement and has not tested and documented the PCREE items yet. Based on observations between 12:40 p.m. and 3:15 p.m. during a tour of the facility with the Administrator 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 Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents and staff and visitors have the potential to be affected but none were. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** On 7/2/2025 the administrator inserviced the maintenance supervisor/ designee/DON on requirements for all PCREE to meet set standards. Maintenance supervisor/designee will ensure testing of PCREE is conducted and documented on all PCREE as part of the facility's annual preventive maintenance program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The maintenance supervisor/designee will review with the administrator the results of the inspection. The administrator will monitor adherence to the preventative maintenance schedule and validate the preventative maintenance documentation is in place. **How the corrective action(s) will be monitored to ensure the**	

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			deficient practice will not recur, i.e., what quality assurance program will be put into place? The inspection results will be presented by the maintenance supervisor/designee to the administrator monthly and the administrator will present the inspection results at the monthly QAPI meeting. Inspection results and system components will be reviewed by the QAPI committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **By what date the systemic changes for each deficiency will be completed?** 7/10/2025	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Based on observation and interview, the facility failed to ensure cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 1 oxygen storage/transfilling room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.3 states storage for nonflammable gases with a total volume equal to or less than greater than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1 and 11.3.3.2. NFPA 99, Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained	K 0923	It is the intent of the facility to ensure cylinders of nonflammable gases such as oxygen are properly secured from falling in oxygen storage/transfilling rooms to meet set standards. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 6/18/2025 the maintenance	07/10/2025

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	or supported in a proper cylinder stand or cart. This deficient practice could affect mostly staff because the West Unit is currently closed to residents, except 1 or 2 residents while using the Therapy gym. Findings include: Based on observation on 06/17/25 at 12:25 p.m. during a tour of the facility with the Administrator and Maintenance Director, there were two small "E" sized oxygen cylinders freestanding on the floor in oxygen storage/transfilling room. Both oxygen cylinders were not supported in a proper cylinder stand or otherwise secured from falling. Based on interview at 12:25 p.m., the Maintenance Director acknowledged the two oxygen cylinders freestanding on the floor and not supported in a cylinder stand or otherwise secured from falling. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		supervisor/DON/designee secured the 2 small "e" sized oxygen cylinders in the oxygen storage/transfilling room to meet set standards. The administrator verified the work on 6/18/2025. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents, staff and visitors have the potential to be affected but none were. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** On 7/2/2025 the administrator inserviced the maintenance staff/DON/nursing staff on the requirement to properly store and handle oxygen including properly securing the oxygen containers to meet set standards. The maintenance supervisor/DON/nursing staff will ensure to properly store and handle oxygen as part of the facility's oxygen polices, procedures, and inspections and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The maintenance supervisor/designee will review with the administrator	

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	155274	A. BUILDING 01 B. WING	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			the inspection results. The administrator will monitor adherence to the preventative maintenance schedule and validate the preventative maintenance documentation is in place. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The inspection results will be presented by the maintenance director/designee/DON to the administrator monthly and the administrator will present the inspection results at the monthly QAPI meeting. Inspection results and system components will be reviewed by the QAPI committee with subsequent plans of corrections developed and implemented as deemed necessary to ensure compliance is maintained. **By what date the systemic changes for each deficiency will be completed?** 7/10/2025	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room where oxygen transfilling takes place, was provided with	K 0927	It is the intent of the facility to ensure the oxygen storage room where the oxygen transfilling takes	07/10/2025

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	properly maintained mechanical ventilation. This deficient practice could affect mostly staff because the West Unit is currently closed to residents, except 1 or 2 residents while using the Therapy gym. Findings include: Based on observation on 06/17/25 at 12:26 p.m. during a tour of the facility with the Administrator and Maintenance Director, the oxygen storage/transfilling room was equipped with a mechanically vented exhaust fan, however, it was covered with dirt/dust at the time of observation. Based on interview at the time of observation, the Maintenance Director agreed the mechanically vented exhaust fan was covered with dirt/dust. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		place is provided with properly maintained mechanical ventilation to meet set standards. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 6/20/2025 the maintenance supervisor replaced the mechanically vented exhaust fan in the oxygen storage/transfilling room to meet set standards. The administrator verified the work on 6/20/2025. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents, staff and visitors have the potential to be affected but none were. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** On 7/2/2025 the administrator inserviced the maintenance supervisor to ensure vented exhaust fans are clean and free of dust/dirt to meet standards. The maintenance supervisor will ensure vented exhaust fans are clean and free of dust/dirt as part	

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			of the facility's oxygen policy and procedures and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The maintenance supervisor/designee will review with the administrator the inspection results. The administrator will monitor adherence to the preventative maintenance schedule and validate the preventative maintenance documentation is in place. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The inspection results will be presented by the maintenance director/designee/DON to the administrator monthly and the administrator will present the inspection results at the monthly QAPI meeting. Inspection results and system components will be reviewed by the QAPI committee with subsequent plans of corrections developed and implemented as deemed necessary to ensure compliance is maintained. **By what date the systemic changes for each deficiency will be completed?**	

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			7/10/2025	