STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155354	A. BUILDING -- B. WING	04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 02/25/25 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/21/25 Facility Number: 000245 Provider Number: 155354 AIM Number: 1002890800 At this PSR to the Emergency Preparedness survey, Newburgh Health Care was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 114 certified beds. At the time of the survey, the census was 58. Quality Review completed on 04/30/25 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance. We respectfully request a paper compliance/desk review.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.1 Develop EP Plan, Review and Update Annually Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all residents in the facility. Findings include:	E 0004	-What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this tag.	05/12/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ally Lopp	Administrator	05/12/2025

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

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	Based on review of the Emergency Preparedness Manual on 04/21/25 at 1:15 p.m. with the Director of Nursing (DON) present, the facility did provide an emergency preparedness manual, however, it has not been reviewed and updated during the past twelve months. The most recent date of review on the cover of the manual was 04/20/22. Based on interview at 1:15 p.m., the DON confirmed there was no evidence the Emergency Preparedness Manual has not been reviewed and updated within the past twelve month period. This finding was reviewed with the DON and Business Office Manager during the exit conference. This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		-How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? No other residents were affected. The emergency manual was reviewed and updated as necessary on 5-12-2025. -What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? A checklist has been created for the Administrator/Designee to review the emergency preparedness plan manual with the interdisciplinary team at least annually. -How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The facility will ensure the emergency preparedness plan manual is reviewed and updated on an annual basis. The facility will maintain documentation of the annual review. Ongoing, the Administrator or designee will monitor and maintain documentation for the purposes of surveyor verification to ensure continued compliance. Results of the monitoring will be reviewed during the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Monitoring will be ongoing.	

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E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.1 Development of EP Policies and Procedures Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: Based on review of the Emergency Preparedness Manual on 04/21/25 at 1:15 p.m. with the Director of Nursing (DON) present, there was documentation in the plan for facility policies and procedures, however the policies and procedures have not been reviewed by the facility within the most recent twelve month period. The most recent date of review on the cover of the manual was 04/20/22. Based on interview at 1:15 p.m., the DON confirmed there was no proof the policies and procedures within the Emergency Preparedness Manual have not been reviewed and updated within the past twelve month period. This finding was reviewed with the DON and Business Office Manager during the exit conference. This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence.	E 0013	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this tag. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? No other residents were affected. The emergency manual was reviewed and updated as necessary on 5-12-2025. measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? A checklist has been created for the Administrator/Designee to review the emergency preparedness plan manual with the interdisciplinary team at least annually. How will the corrective action(s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The facility will ensure the emergency preparedness policies and procedures within the plan are reviewed and updated on an annual basis. The facility will maintain documentation of the annual review. Ongoing, the Administrator or designee will monitor and maintain	05/12/2025

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			documentation for the purposes of surveyor verification to ensure continued compliance.¿ Results of the monitoring will be reviewed during the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Monitoring will be ongoing.	
E 0025 SS=C Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b) Arrangement with Other Facilities Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents in accordance with 42 CFR 483.73(b)(7). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Manual on 04/21/25 at 1:15 p.m. with the Director of Nursing (DON) present, documentation of emergency preparedness policies and procedures including the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations was available for review, however, the dates on the LTC facilities and other provider was listed 2017 and 2018 for the various facilities. Based on interview at 1:15 p.m., the DON agreed the documentation of arrangements with other facilities needs to be updated. This finding was reviewed with the DON and Business Office Manager during the exit	E 0025	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this tag. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? No other residents were affected. The emergency manual was reviewed and updated as necessary on 5-12-2025. Mutual aid agreements have been sent to the various vendors to be signed, updated, and placed back in the EP manual. measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? A checklist has been created for the Administrator/Designee to review the emergency preparedness plan manual with the interdisciplinary team at least annually. How will the corrective action(s be	05/12/2025

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	conference. This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The facility will ensure the emergency preparedness policies and procedures within the plan are reviewed and updated on an annual basis. The facility will maintain documentation of the annual review. Ongoing, the Administrator or designee will monitor and maintain documentation for the purposes of surveyor verification to ensure continued compliance.¿ Results of the monitoring will be reviewed during the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Monitoring will be ongoing.	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.1 Development of Communication Plan Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Manual on 04/21/25 at 1:15 p.m. with the Director of Nursing (DON) present, the facility's emergency preparedness plan did include a plan to develop and maintain an emergency	E 0029	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this tag. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? No other residents were affected. The emergency manual was reviewed and updated as necessary on 5-12-2025. measures will be put into place and what systemic	05/12/2025

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	preparedness communication plan that complies with Federal, State, and local laws, however the communication plan has not been reviewed by the facility within the most recent twelve month period. The most recent date of review on the cover of the manual was 04/20/22. Based on interview at 1:15 p.m., the DON confirmed there was no proof the Communication Plan within the Emergency Preparedness Manual has not been reviewed and updated within the past twelve month period. This finding was reviewed with the DON and Business Office Manager during the exit conference. This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		changes will be made to ensure that the deficient practice does not recur? A checklist has been created for the Administrator/Designee to review the emergency preparedness plan manual with the interdisciplinary team at least annually. How will the corrective action(s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The facility will ensure the emergency preparedness communication plan is reviewed and updated on an annual basis. The facility will maintain documentation of the annual review. Ongoing, the Administrator or designee will monitor and maintain documentation for the purposes of surveyor verification to ensure continued compliance.¿ Results of the monitoring will be reviewed during the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Monitoring will be ongoing.	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.1 EP Training and Testing Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants.	E 0036	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this	05/12/2025

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	Findings include: Based on review of the Emergency Preparedness Manual on 04/21/25 at 1:15 p.m. with the Director of Nursing (DON) present, there was documentation available to show the facility had an emergency preparedness training and testing program, however the training and testing program has not been reviewed by the facility within the most recent twelve month period. The most recent date of review on the cover of the manual was 04/20/22. Based on interview at 1:15 p.m., the DON confirmed there was no proof the training and testing policy and procedure within the Emergency Preparedness Manual has not been reviewed and updated within the past twelve month period. This finding was reviewed with the DON and Business Office Manager during the exit conference. This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		tag How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? No other residents were affected. The emergency manual was reviewed and updated as necessary on 5-12-2025. measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? A checklist has been created for the Administrator/Designee to review the emergency preparedness plan manual with the interdisciplinary team at least annually. How will the corrective action(s be monitored to ensure the deficient practice will not recur, i.e., what	

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			quality assurance program will be put into place? The facility will ensure the emergency preparedness training and testing program is reviewed and updated on an annual basis. The facility must maintain documentation of the annual review. Ongoing, the Administrator or designee will monitor and maintain documentation for the purposes of surveyor verification to ensure continued compliance.¿ Results of the monitoring will be reviewed during the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Monitoring will be ongoing.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation	E 0039	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this tag How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? No other residents were affected. There was a second exercise conducted that began on 5-7-2025, this exercise	05/14/2025

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	of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants in the facility. Findings include: Based on review of the Emergency Preparedness Manual on 04/21/25 at 1:15 p.m. with the Director of Nursing (DON) present, the facility was able to provide documentation of an actual event, a fire in the facility on 02/03/25, however, there was no documentation of a second exercise conducted by the facility during the past 12 month period. This was confirmed by the DON at 1:15 p.m.. This finding was reviewed with the DON and Business Office Manager during the exit conference.		is on-going. measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? A checklist has been created for the Administrator/Designee to review the emergency preparedness plan manual with the interdisciplinary team at least annually. How will the corrective action(s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The facility will ensure at least two emergency preparedness exercises utilizing the emergency preparedness plan are conducted on an annual basis. The facility will maintain documentation of the exercises and subsequent analysis. Ongoing, the Administrator or designee will monitor and maintain documentation for the purposes of surveyor verification to ensure continued compliance.¿ Results of the monitoring will be reviewed during the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Monitoring will be ongoing.	

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E 0041 SS=F Bldg. --	This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence. 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). Based on record review and interview, the facility failed to ensure a written record of routine maintenance and testing for 1 of 1 emergency generator was maintained and available for review. NFPA 110, the Standard for Emergency and Standby Powers Systems, at 8.3.3 requires a written schedule for routine maintenance and operational testing of the EPSS shall be established. 8.3.4 requires a permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. 8.3.4.1 requires the permanent record shall include the following: (1) The date of the maintenance report (2) Identification of the servicing personnel (3) Notification of any unsatisfactory condition and the corrective action taken, including parts replaced (4) Testing of any repair for the time as recommended by the manufacturer. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 04/21/25 at 3:00 p.m. with the Director of Nursing (DON) and Business Office Manager present, there was no	E 0041	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this tag. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? No other residents were affected by this tag The generator did have preventative maintenance on August 8th, 2024. The facility has also renewed the contract for maintenance to be performed in 2025.	05/14/2025

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	documentation available to show the emergency generator has had routine maintenance during the past 12 months. The most recent routine maintenance report for the emergency generator was dated 01/09/24, which was over three months past due. Based on interview at 3:00 p.m., the Business Office Manager said she contacted the generator maintenance vendor and they sent her a report of emergency generator service, however, it was not provided with a date of service. This finding was reviewed with the DON and Business Office Manager during the exit conference. This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? A checklist has been created for the Maintenance Director to review with the Administrator/Designee to ensure routine maintenance and testing for the emergency generator is documented and maintained for review. How will the corrective action(s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The facility will ensure the emergency generator is maintained to ensure to a reasonable degree that the generator is capable of supplying emergency power within the time specified and for the time duration specified within NFPA 110, Standard for Emergency and Standby Power Systems.¿The continuing reliability and integrity of the Emergency Power Supply System (EPSS) are dependent on an established program of routine maintenance and operational	

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			testing. Ongoing, the Administrator or will monitor the routine maintenance and operational testing program to ensure continued compliance.¿ Results of the monitoring will be reviewed during the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Monitoring will be ongoing.	
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 02/25/25 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/21/25 Facility Number: 000245 Provider Number: 155354 AIM Number: 100290800 At this PSR to the Life Safety Code survey, Newburgh Health Care was found not 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	K 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance. We respectfully request a paper compliance/desk review.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 114 and had a census of 58 at the time of this survey. All areas where the residents have customary access were sprinklered, and all areas providing facility services, including a detached garage used for a maintenance shop and maintenance and facility storage, were sprinklered, except a small detached wood framed shed used for furniture storage and a walk in cooler outside the kitchen service hall exit. Quality Review completed on 04/30/25			
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lighting Based on record review and interview, the facility failed to ensure documentation was provided for the testing of 1 of 1 battery powered emergency light unit that was tested monthly for 30 seconds during 3 of the past 12 months, and annually for 90 minutes during the past 12 months to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. 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, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all	K 0291	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this tag. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? No other residents were affected.	05/14/2025

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	155354	A. BUILDING 01 B. WING	04/21/2025

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	residents, as well as staff and visitors in the facility. Findings include: Based on record review on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director present, the facility did have a line item on the emergency generator monthly load testing form indicating emergency lighting was tested monthly. There was no documentation on the form for November and December of 2024 and January of 2025 that the emergency light was tested for 30 seconds. Furthermore, there was no documentation available to show the battery powered emergency light unit was tested annually for 90 minutes during the past 12 month period. Based on interview at the time of record review, the Maintenance Director said he does test the battery powered emergency light unit at the generator during each monthly load test, but must have forgotten to document the 30 second tests for November and December of 2024 and January of 2025. He further said there is no documentation of a 90 minute test of the battery powered emergency light unit available for review. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. Based on interview on 04/21/25 at 3:00 p.m., the Director of Nursing said the Administrator and Maintenance Director were not in the facility today and she was not able to locate the Plan of Correction folder to show this deficiency has been corrected. This finding was reviewed with the DON and Business Office Manager during the exit		The annual 90-minute testing of the emergency light has been performed. A checklist has been created for the Maintenance Director to review with the Administrator/Designee to ensure routine maintenance and testing for the emergency generator is documented and maintained for review. MEASURES TO PREVENT REOCCURRENCE: The facility will use the current form to document the testing of the battery-operated emergency light. A 30-second monthly log and 90-minute annual log is set up and itemized to include the battery-powered emergency light by the emergency generator. The battery backup light will be tested monthly, and findings documented in the logbook. measures will be put into place and what systemic changes will	

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	conference. 3.1-19(b) This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		be made to ensure that the deficient practice does not recur? The itemized log/documentation will be reviewed by the Administrator/Designee for completion as required and will be presented by the Maintenance Supervisor/designee to the Administrator monthly. Any area or areas of concern will be reviewed and addressed as necessary at this time. Results will be reviewed at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Monitoring will be ongoing. How will the corrective action(s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The audit will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	

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K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other 1. 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 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 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Administrator and the Maintenance Director present, the "Maintenance Log for Resident Room Smoke Detector Test" 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 the time of record review, 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.	K 0300	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? All residents have the potential to be affected. A smoke detector battery test check has been performed according to the devices manufacturers' guidelines, please see attachment Q. The smoke detectors will continue to be tested weekly per manufacturer guidelines. All residents have the potential to be affected. The Maintenance Director/ Designee has replaced all batteries for the resident smoke alarms and has documented to indicate battery replacement as of 5-12-2025. This documentation will remain documented in the logbook. measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? A smoke detector battery test check will be performed weekly according to the devices manufacturers' guidelines. The	05/14/2025

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	Based on interview on 04/21/25 at 3:00 p.m., the Director of Nursing said the Administrator and Maintenance Director were not in the facility today and she was not able to locate the Plan of Correction folder to show this deficiency has been corrected. This finding was reviewed with the DON and Business Office Manager during the exit conference. 3.1-19(b) This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence. 2. Based on record review and interview, the facility failed to ensure documentation for the preventative maintenance of battery operated smoke alarms in all resident rooms was complete. NFPA 72 14.2.1.1.1 states to ensure operations integrity, the system shall have an inspection, testing, and maintenance program. NFPA 72 29.10 states fire-warning equipment shall be maintained and tested in accordance with manufacturer's published instructions and per the requirements of Chapter 14. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director present, the battery operated smoke alarm maintenance documentation failed to indicate battery replacement during the past 12 month period or prior. The most recent battery replacement was documented on 01/18/24, which		Maintenance Director/Designee has completed the weekly battery checks for all residents' rooms and will continue to do per manufacturer guidelines. A checklist has been created for the Maintenance Director to review with the Administrator/Designee to ensure weekly tests of the battery-operated smoke alarms is documented and maintained for review and corrections will be made as soon as possible if necessary. See attachment E. The testing dates and results will be documented in the for review. The Maintenance Director/ Designee has replaced all batteries for the resident smoke alarms and has documented to indicate battery replacement as of 5-12-2025. This documentation will remain documented in the logbook. A checklist has been created for the Maintenance Director to review with the Administrator/Designee to ensure the batter-operated smoke alarms batteries are replaced annually and is documented and maintained for review and corrections will be made as soon as possible if necessary. How will the corrective action(s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance	

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	is over a month past due. Based on interview at the time of record review, the Maintenance Director confirmed the batteries in the resident room smoke alarms have not been replaced in the past 12 month period. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. Based on interview on 04/21/25 at 3:00 p.m., the Director of Nursing said the Administrator and Maintenance Director were not in the facility today and she was not able to locate the Plan of Correction folder to show this deficiency has been corrected. This finding was reviewed with the DON and Business Office Manager during the exit conference. 3.1-19(b) This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		Director and facility Administrator will monitor the testing dates and log for consistency and proceed with the appropriate follow-up as soon as possible. The results of the smoke detector checks will be presented in the monthly Quality Assurance / Performance Improvement Meeting. The monitoring will be ongoing to reflect the various opportunities for action. The facility will ensure battery-operated smoke alarms within the facility are maintained in accordance with NFPA 72, National Fire Alarm and Signaling Code, 2010 edition. NFPA 72, 29.10 states that fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14.¿ NFPA 72, 14.2.1.1.1 states that inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. Ongoing, the Administrator or will monitor the battery-operated smoke alarms to ensure continued compliance.¿ Results of the monitoring will be reviewed during the facility's monthly Quality Assurance meeting; monitoring will be ongoing.	

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K 0324 SS=F Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2, states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 states the fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 states an approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice could affect mostly kitchen staff. Findings include: Based on observations on 02/25/25 between 3:00 p.m. and 5:30 p.m. during a tour of the facility with the Administrator and Maintenance Director, the stove located under the range hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to	K 0324	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this tag How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? No other residents were affected. The Maintenance Director has taped the specific area the equipment needs to be placed back into after been moved for the purposes of maintenance and cleaning to ensure in compliance with the manufacture guidelines. measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Residents who are in the area of the dining room have the potential to be affected. The Maintenance Director has taped the specific area the equipment needs to be	05/12/2025

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	an approved designed location after it had been moved for maintenance and/or cleaning. Based on interview at the time of observation, the Administrator and Maintenance Director said they were not aware an approved method had to be provided to ensure the appliances were returned to an approved designed location after maintenance or cleaning. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. Based on interview on 04/21/25 at 3:00 p.m., the Director of Nursing said the Administrator and Maintenance Director were not in the facility today and she was not able to locate the Plan of Correction folder to show this deficiency has been corrected. This finding was reviewed with the DON and Business Office Manager during the exit conference. 3.1-19(b) This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		placed back into after been moved for the purposes of maintenance and cleaning to ensure in compliance with the manufacture guidelines. The kitchen staff have been in- on this update. How will the corrective action(s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The facility will ensure kitchen fire suppression systems within the facility are maintained in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 ¿NFPA 96, Section 4.1.2 states all such equipment and its performance shall be maintained in accordance with the requirements of this standard during all periods of operation of the cooking equipment.¿Section 12.1.2.2, states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section	

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			12.1.2.3 states the fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 states an approved method shall be provided that will ensure that the appliance is returned to an approved design location. Ongoing, the Administrator or will monitor the kitchen fire suppression system to ensure continued compliance.¿ Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing.	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Based on record review and interview, the facility failed to provide a complete written policy for the protection of all occupants indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants in the facility.	K 0346	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this tag	05/14/2025

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	Findings include: Based on record review on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Administrator and Maintenance Director present, the facility did provide fire watch documentation from the Emergency Preparedness Manual, however, it was incomplete. The plan failed to include contacting the IDOH with the web link for contacting the Incident Reporting System located on the IDOH Gateway. Based on an interview at the time of record review, this was confirmed by the Administrator. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. Based on interview on 04/21/25 at 3:00 p.m., the Director of Nursing said the Administrator and Maintenance Director were not in the facility today and she was not able to locate the Plan of Correction folder to show this deficiency has been corrected. This finding was reviewed with the DON and Business Office Manager during the exit conference. 3.1-19(b) This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? A checklist has been created for the Administrator/Designee to review the emergency preparedness plan manual with the interdisciplinary team at least annually. measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The policy & procedure was updated to include contacting the IDOH with the web link for contacting the Incident Reporting System located on the IDOH Gateway and includes contact information for the facilities insurance carrier.	

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			How will the corrective action(s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The facility will ensure that a complete facility-specific written fire safety plan for the protection of all residents is established. The facility will ensure all health care occupancy personnel are periodically instructed all aspects of the written fire safety plan. Emphasis must be placed on¿addressing evacuation of the smoke compartments and identifying where the smoke barriers were located in the facility and evacuation in detail as well as addressing staff response to the activation of¿battery powered smoke alarms in the resident rooms, training staff to sound the fire alarm, to rescue residents (as needed), and to close all doors. ¿ Ongoing, the Administrator or will monitor training documentation to ensure all employees of health care occupancies have received instruction in life safety procedures and devices to ensure continued compliance.¿ Results of the monitoring will be reviewed during the facility's monthly	

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			Quality Assurance/Performance Improvement (QA/PI) meeting. Monitoring will be ongoing.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping system was inspected every five years in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 14.2.1 states an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. Alternative nondestructive examination methods shall be permitted. Non-metallic pipe shall not be required to be inspected internally. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director present, documentation of an internal inspection of the sprinkler system performed within the most recent five year period was not available for review. Documentation for the most recent	K 0353	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this tag. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? No other residents were affected. measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? A checklist has been created for the Maintenance Director to review with the Administrator/Designee to ensure the automatic sprinkler piping system is inspected every five years in accordance with NFPA 25 and is documented and maintained for review. The Maintenance Director will review the schedule / log with the facility Administrator. A summary of the report will be reviewed at the next monthly Quality Assurance/Performance Improvement (QA/PI) meeting and	05/14/2025

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	internal pipe inspection performed was dated 01/14/20, which was over a month past due. Based on interview at the time of record review, the Maintenance Director said there is no scheduled date for the sprinkler vendor to perform the internal pipe inspection/investigation, but he will contact and schedule them as soon as possible. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. Based on interview on 04/21/25 at 3:00 p.m., the Director of Nursing said the Administrator and Maintenance Director were not in the facility today and she was not able to locate the Plan of Correction folder to show this deficiency has been corrected. This finding was reviewed with the DON and Business Office Manager during the exit conference. 3.1-19(b) This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		as needed. The sprinkler system has been assessed and completed by Tristate Fire Protection. How will the corrective action(s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The facility will ensure the sprinkler system operates as designed, receives an unobstructed flow of water, and is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.¿ The facility will ensure issues are addressed promptly when identified. If evidence of the presence of sufficient material to potentially obstruct pipe or sprinklers is noted, a complete flushing program shall be conducted by qualified personnel.¿Inspection, test, and maintenance records will be available for review. Ongoing, the Administrator or designee will monitor the sprinkler system inspection, tests, and maintenance documentation to ensure continued compliance.¿ Results of the monitoring will be reviewed during the facility's monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Monitoring will be ongoing.	

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	155354	A. BUILDING 01 B. WING	04/21/2025

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K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed for the protection of all residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Administrator and Maintenance Director present, the facility provided fire watch documentation from the Emergency Preparedness Manual, however, it was incomplete. The plan failed to include contacting the Indiana Department of Health (IDOH) with the web link for contacting the Incident Reporting System located on the IDOH Gateway, furthermore, the plan failed to include contact	K 0354	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this tag. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? No other residents were affected. measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The policy & procedure was updated to include contacting the IDOH with the web link for contacting the Incident Reporting System located on the IDOH Gateway and includes contact information for the facilities insurance carrier. How will the corrective action(s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The facility will ensure the sprinkler system operates as designed, receives an unobstructed flow of water, and is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.¿ The facility will ensure issues are addressed	05/14/2025

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	information for the facilities insurance carrier with contact information. Based on an interview at the time of record review, the Administrator agreed the fire watch policy lacked the previously mentioned information. This finding was reviewed with the Administrator and Maintenance Director during the exit conference Based on interview on 04/21/25 at 3:00 p.m., the Director of Nursing said the Administrator and Maintenance Director were not in the facility today and she was not able to locate the Plan of Correction folder to show this deficiency has been corrected. This finding was reviewed with the DON and Business Office Manager during the exit conference. 3.1-19(b) This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		promptly when identified. If evidence of the presence of sufficient material to potentially obstruct pipe or sprinklers is noted, a complete flushing program shall be conducted by qualified personnel.¿Inspection, test, and maintenance records will be available for review. Ongoing, the Administrator or designee will monitor the sprinkler system inspection, tests, and maintenance documentation to ensure continued compliance.¿ Results of the monitoring will be reviewed during the facility's monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Monitoring will be ongoing.	
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Based on record review and interview, the facility failed to provide a complete facility specific written fire safety plan for the protection of all residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms	K 0711	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this tag	05/14/2025

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	(2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the facility's Fire Procedure plan on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Administrator and Maintenance Director present, the plan did not address the following: a. The plan did not address evacuation of the smoke compartment, furthermore, the plan did not identify where the smoke barriers were located in the facility and evacuation in detail. b. The plan did not address staff response to the activation of battery powered smoke alarms in the resident rooms. Based on interview at the time of record review, the Administrator and Maintenance Director		How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? No other residents were affected measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The plan was updated to address: -evacuation of the smoke compartment ·-to identify where the smoke barriers the facility and evacuation in detail ·-staff response to the activation of battery powered smoke alarms in the resident rooms (i.e., staff are alerted to smoke alarm, rescues resident, shuts door and then pulls fire alarm)	

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	acknowledged the Fire Procedure plan did not include the previously mentioned items. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. Based on interview on 04/21/25 at 3:00 p.m., the Director of Nursing said the Administrator and Maintenance Director were not in the facility today and she was not able to locate the Plan of Correction folder to show this deficiency has been corrected. This finding was reviewed with the DON and Business Office Manager during the exit conference. 3.1-19(b) This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		How will the corrective action(s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The facility will ensure a complete facility-specific written fire safety plan for the protection of all residents is established. The facility will ensure all health care occupancy personnel are periodically instructed all aspects of the written fire safety plan. Emphasis must be placed on addressing evacuation of the smoke compartments and identifying where the smoke barriers were located in the facility and evacuation in detail as well as addressing staff response to the activation of¿battery powered smoke alarms in the resident rooms, training staff to sound the fire alarm, to rescue residents (as needed), and to close all doors. ¿ Ongoing, the Administrator or will monitor training documentation to ensure all employees of health care occupancies have received instruction in life safety	

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			procedures and devices to ensure continued compliance.¿ Results of the monitoring will be reviewed during the facility's monthly Quality Assurance/Performance Improvement (QA/PI) meeting Monitoring will be ongoing.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills 1. Based on record review and interview, the facility failed to ensure 4 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. Findings include: Based on review of the facility's fire drill reports on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director present, all four third shift 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 4 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	K 0712	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? All others with potential to be affected: The Maintenance Supervisor/designee will ensure the monthly fire drills are completed and documented (including but not limited to date and time) retained in the LSC Binder to meet set standards. Measures to prevent reoccurrence: When the Maintenance Supervisor conducts monthly fire drills for 3 shift between the hours of 10pm and 6am, the maintenance director will pull the fire alarm the following morning to verify the monitoring company has received	05/14/2025

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	and Maintenance Director during the exit conference. Based on interview on 04/21/25 at 3:00 p.m., the Director of Nursing said the Administrator and Maintenance Director were not in the facility today and she was not able to locate the Plan of Correction folder to show this deficiency has been corrected. This finding was reviewed with the DON and Business Office Manager during the exit conference. 3-1.19(b) 3.1-51(c) This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence. 2. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 3 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director present, the following was noted: a. 3 of 4 first shift (day) fire drills were performed between 10:15 a.m. and 10:38 a.m. b. 4 of 4 second shift (evening) fire drills were performed between 2:30 p.m. and 3:15 p.m. c. 3 of 4 third shift (night) fire drills were performed between 10:00 p.m. and 10:40 p.m. Based on interview at the time of record review,		transmission of the alarm. This completed documentation will be placed in the facility's logbook as a part of the facility's Emergency Preparedness Program. If any issues are discovered, they will be addressed and resolved. The Maintenance Director/designee will review with the Administrator the fire drill reports to ensure there is documentation of the transmission of the alarm to the monitoring company. All others with potential to be affected: On 5-12-2025 the Maintenance Supervisor/designee was in-serviced on the requirement that monthly fire drills must be completed and documentation (including but not limited to date and time) retained in the LSC Binder to meet set standards. Measures to prevent recurrence: Maintenance Supervisor will conduct monthly fire drills and place completed documentation in the facility's log Binder as a part of the facility's Emergency Preparedness Program. If any issues are discovered, they will be addressed and resolved. The maintenance director/designee will review with the Administrator the fire drill reports to ensure there is documentation of the transmission of the alarm to the monitoring company. measures will be put into place and what systemic changes will be made to ensure	

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	the Maintenance Director acknowledged the times all three shifts fire drills were performed and agreed the times were not varied enough. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. Based on interview on 04/21/25 at 3:00 p.m., the Director of Nursing said the Administrator and Maintenance Director were not in the facility today and she was not able to locate the Plan of Correction folder to show this deficiency has been corrected. This finding was reviewed with the DON and Business Office Manager during the exit conference. 3.1-19(b) 3.1-51(c) This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		that the deficient practice does not recur? The Administrator will monitor adherence to the fire drill schedule and validate the Emergency Preparedness documentation in place. Monitoring corrective action: The fire drill report will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. The fire drill reports will be presented by the Maintenance Supervisor/designee monthly to the Administrator and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting every month for 6 months. The audit will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. How will the corrective action(s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The facility will ensure fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. Documentation shall be maintained for review by the	

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			authority having jurisdiction and include documenting the transmission of the alarm signal. Ongoing, the Administrator or designee will maintain fire drill documentation to ensure continued compliance.¿ Results of the monitoring will be reviewed during the facility's monthly Quality Assurance/Performance Improvement meeting. Monitoring will be ongoing.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on observation and interview, the facility failed to ensure cigarette butts were properly disposed of at 1 of 1 area where cigarettes were allowed to be smoked by staff. This deficient practice could affect staff only. Findings include: Based on observations on 04/21/25 at 1:45 p.m. during a tour of the facility with the Director of Nursing (DON), the designated staff smoking area outside the rear kitchen exit door had hundreds of cigarette butts scattered on the ground, along with two small metal self closing ash trays on a table and both full of cigarette butts. Based on interview at the time of observation, the DON acknowledged the issues with the cigarette butts on the ground and lack of ways to dispose of the cigarette butts properly. This finding was reviewed with the DON and Business Office Manager during the exit conference.	K 0741	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? No other residents were affected. measures will be put into place and what systemic changes will	05/14/2025

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	3.1-19(b) This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		be made to ensure that the deficient practice does not recur? A designated smoking area is established with self-closing ashtray/smoking tower receptacles of noncombustible material and safe design provided. Signage is prominently displayed with instructions for the disposal of cigarette butts. A smoking policy has been updated, with an addendum included on how to dispose of cigarette butts once the self-closing device is full. Staff will continue to be in-serviced on the Smoking Protocol by the Staff Development Coordinator/designee until compliance with the policy and then annually after. How will the corrective action(s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The facility will ensure staff, residents and visitors adhere to established smoking policies and	

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			procedures.¿ Smoking materials are discarded properly in areas where smoking is permitted and not permitted. Ongoing, the Administrator or will monitor smoking areas and nonsmoking areas to ensure proper disposal of discarded smoking materials to ensure continued compliance.¿ Results of the monitoring will be reviewed during the facility's monthly Quality Assurance meeting. Monitoring will be ongoing.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to ensure a written record of routine maintenance and testing for 1 of 1 emergency generator was maintained and available for review. NFPA 110, the Standard for Emergency and Standby Powers Systems, at 8.3.3 requires a written schedule for routine maintenance and operational testing of the EPSS shall be established. 8.3.4 requires a permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. 8.3.4.1 requires the permanent record shall include the following: (1) The date of the maintenance report (2) Identification of the servicing personnel (3) Notification of any unsatisfactory condition and the corrective action taken, including parts replaced (4) Testing of any	K 0918	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this tag. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? No other residents were affected by this tag The generator did have preventative maintenance on August 8th, 2024. The facility has also renewed the contract for maintenance to be performed in 2025. measures will be put into	05/14/2025

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	repair for the time as recommended by the manufacturer. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 04/21/25 at 3:00 p.m. with the Director of Nursing (DON) and Business Office Manager present, there was no documentation available to show the emergency generator has had routine maintenance during the past 12 months. The most recent routine maintenance report for the emergency generator was dated 01/09/24, which was over three months past due. Based on interview at 3:00 p.m., the Business Office Manager said she contacted the generator maintenance vendor and they sent her a report of emergency generator service, however, it was not provided with a date of service. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. Based on interview on 04/21/25 at 3:00 p.m., the Director of Nursing said the Administrator and Maintenance Director were not in the facility today and she was not able to locate the Plan of Correction folder to show this deficiency has been corrected. This finding was reviewed with the DON and Business Office Manager during the exit conference. This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		place and what systemic changes will be made to ensure that the deficient practice does not recur? A checklist has been created for the Maintenance Director to review with the Administrator/Designee to ensure routine maintenance and testing for the emergency generator is documented and maintained for review. How will the corrective action(s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The facility will ensure the emergency generator is maintained to ensure to a reasonable degree that the generator is capable of supplying emergency power within the time specified and for the time duration specified within NFPA 110, Standard for Emergency and Standby Power Systems.¿The continuing reliability and integrity of the Emergency Power Supply System (EPSS) are dependent on an established program of routine maintenance and operational testing. Ongoing, the Administrator or will monitor the routine maintenance and operational testing program to ensure continued compliance.¿ Results of the monitoring will be reviewed during the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Monitoring will be ongoing.	

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K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure extension cords were not used as a substitute for fixed wiring in 1 of 64 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 one resident. Findings include: Based on observations on 04/21/25 at 1:35 p.m. during a tour of the facility with the Director of Nursing (DON), a string of white Christmas lights (approximately 100 to 200 lights) hanging over the window curtains and turned on at the time of observation. This was acknowledged by the DON at 1:35 p.m.. This finding was reviewed with the DON and Business Office Manager during the exit conference. 3.1-19(b) This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence.	K 0920	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this tag How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? No other residents were affected by this tag. The resident's family removed the Christmas lights from the resident's room. The Maintenance director has audited all other residents' rooms to remove extension cords, power strips, and/or Christmas lights out of resident rooms if they do not comply with NFPA 70, National Electrical Code, 2011 measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? A checklist has been created for the Maintenance Director to review with the Administrator/Designee to ensure extension cords are not used as a substitute for fixed wiring and is documented and maintained for review. How will the corrective action(s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The facility will ensure	05/14/2025

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	155354	A. BUILDING 01 B. WING	04/21/2025

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			compliance with power cord and extension cord requirements. Ongoing, the Administrator or will monitor the facility to ensure continued compliance with power cord and extension cord requirements.¿ Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing.	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review, observation, and interview; the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is	K 0921	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this tag. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? No other residents were affected by this tag. The company "" was contacted on 5/11/2025 and 5/12/2025 to request them to perform an assessment of the building equipment to be tested accordingly. The facility has requested this company to test equipment such as electric beds, nebulizers, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment.	05/16/2025

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	155354	A. BUILDING 01 B. WING	04/21/2025

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	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 02/25/25 between 10:00 a.m. and 3:00 p.m. with the 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 the time of record review, the Maintenance Director said the facility has not tested and documented the PCREE items and was not aware of the requirement. Based on observation between 3:00 p.m. to 5:30 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. Based on interview on 04/21/25 at 3:00 p.m., the Director of Nursing said the Administrator and Maintenance Director were not in the facility today and she was not able to locate the Plan of Correction folder to show this deficiency has been corrected. This finding was reviewed with the DON and Business Office Manager during the exit		measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? A checklist has been created for the Maintenance Director to review with the Administrator/Designee to ensure the required maintenance is maintained of complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE) is documented and maintained for review. How will the corrective action(s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The facility will ensure patient care-related electrical equipment (PCREE) is tested at intervals established by the facility's own policy and procedures. (based on manufacturer's guidelines) Inspection and testing will include the following for fixed and portable PCREE: Physical integrity	

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	conference. 3.1-19(b) This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		Resistance Leakage current Touch current tests All PCREE used in resident rooms shall be tested before being put service and after any repairs or modification. Service manuals and manufacturer's guidelines must be considered in the development of an electrical equipment maintenance program. Instructions and maintenance manuals shall be readily available. Safety labels and condensed operating instructions shall be legible. Documentation is maintained of all tests, repairs, and modifications in accordance with the facility's PCREE policy and procedure. Personnel responsible for the testing, maintenance and use of electrical appliances shall receive continuing training.	