STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155495	A. BUILDING -- B. WING	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PADDOCK SPRINGS	2695 SHELDON STREET WARSAW, IN 46582

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/26/23 Facility Number: 000491 Provider Number: 155495 AIM Number: 100291230 At this Emergency Preparedness survey, Paddock Springs, 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 54. Quality Review completed on 10/31/23	E 0000		
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Humberto Nunez		11/10/2023

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

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	§485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies			

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	and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies			

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	and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the			

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	CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to conduct annual training for the	E 0037	E – 037 – Emergency Preparedness Training Program	11/10/2023

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	Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on record review with the Regional Facilities Director and the Maintenance Director on 10/26/23 at 10:59 a.m., the annual EPP training, what the training consisted of, and if staff could demonstrate knowledge of the EPP was not provided for review during the survey. Based on an interview at the time of records review, the Maintenance Director stated all staff have completed the emergency preparedness training on the training system but was unable to show completed training. This finding was reviewed with the Maintenance Director and the Regional Facilities Director at the exit conference. 3.1-19(b)		1 The deficient practice has the potential to affect all residents in the facility. The Director of Plant Operations and Executive Director have educated all staff in the campus on the Emergency Preparedness Plan. According to CFR 483.73(d) (1). 2 The Director of Plant Operations was educated by the Executive Director on E037 Emergency Preparedness Training Program including the appropriate intervals for staff training. 3 The Executive Director will verify the Emergency Preparedness Training Program completion upon completion of updated training. 4 As a quality measure, the ED or designee will review any findings and corrective action ongoing while the campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. Compliance date of November 10, 2023.	
K 0000 Bldg. 02	A Life Safety Code Survey was conducted by the Indiana Department of Health in accordance with	K 0000		

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	42 CFR 483.90(a). Survey Date: 10/26/23 Facility Number: 000491 Provider Number: 155495 AIM Number: 100291230 At this Life Safety Code survey, Paddock Springs 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 18, New Health Care Occupancies and 410 IAC 16.2. This one story facility constructed in 2018 was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wire smoke detection in the corridors, areas open to the corridors and in all resident rooms. The facility is fully protected by a Type II ESS 150 kW Natural Gas generator. The Healthcare Facility is connected to an Assisted Living Facility (Residential Board and Care Occupancy) from which it is separated by a Fire Wall with a 2-hour Fire Resistance Rating. All areas where the residents will have customary access were sprinklered. The facility has a capacity of 60 and had a census of 54 at the time of this survey. Quality Review completed on 10/31/23			
K 0223 SS=F Bldg. 02	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier,			

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	or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: *Required manual fire alarm system; and *Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and *Automatic sprinkler system, if installed; and *Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure 1 of 2 separation doors between LTC and AL are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2. This deficient practice could affect all residents in the dining room. Findings include: Based on observation with the Regional Facilities Director and the Maintenance Director on 10/26/23 at 11:39 a.m., the separation fire door in the kitchen which is also used as a horizontal exit was held open by a door wedge that would not release the door upon activation of the fire alarm. Based on interview at the time of observation, Maintenance Director removed the door stop and stated staff will be trained on not to prop the door open. This finding was reviewed with the Maintenance Director and the Regional Facilities Director at the exit conference. 3.1-19(b)	K 0223	K – 223 – Doors with Self-Closing Devices 1 The deficient practice has the potential to affect all residents in the facility. The Director of Plant Operations has acquired all inappropriate door wedges within the campus. According to Reference Code 7.2.1.8.2. 2 Facility staff have been educated on not propping doors open with any type of door wedge or door stops. 3 The DPO or designee will audit the doors to ensure no inappropriate wedges or stops are propping doors open weekly for six weeks. 4 As a quality measure, the DPO or designee will review any findings and corrective action monthly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance	11/10/2023

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			Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. Compliance date of November 10, 2023.	
K 0321 SS=E Bldg. 02	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 New Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a 3/4-hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 and less than 100 square feet) g. Combustible Storage Rooms/Spaces (over 100 square feet) h. Laboratories (if classified as Severe			

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	Hazard - see K322) Based on observation and interview the facility failed to ensure 1 of 9 hazardous area was protected in accordance with 18.3.2.1. Hazardous areas shall be enclosed with a 1-hour fire-rated barrier, with a 3/4-hour fire-rated door without windows (in accordance with 8.7.1.1). This deficient practice could affect 15 residents in the 400-hall. Findings include: Based on observation Regional Facilities Director and the Maintenance Director on 10/26/23 at 11:23 a.m., the 400-hall janitor closet was a hazardous area containing 15 highly flammable (according to the product information) aerosol cans. The door to the room was not fire-rated and the walls were not rated as a one-hour fire barrier. Based on interview at the time of observation, the Maintenance Director stated there was no fire-rating on the door and according to the construction plans the room was not a one-hour fire rated room. This finding was reviewed with the Maintenance Director and the Regional Facilities Director at the exit conference. 3.1-19(b)	K 0321	K – 321 – Hazardous Area - Enclosure 1 The deficient practice has the potential to affect all residents residing on 400 hall. The Director of Plant Operations has removed all flammable materials from the janitor supply closet and placed them in the appropriate flammable cabinet. According to Reference Code 18.3.2.1. and Reference Code 8.7.1.1. 2 Facility staff have been educated on storing flammable materials in any areas of the facility without hazardous protection. 3 The DPO or designee will audit the janitor and supply closets to ensure no inappropriate products are being stored in them weekly for six weeks. 4 As a quality measure, the DPO or designee will review any findings and corrective action monthly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. Compliance date of November 10, 2023.	11/10/2023

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K 0324 SS=F Bldg. 02	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: *residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. *cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or *cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchens. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect staff in the kitchen and all residents in the dining room. Findings include: Based on observation with the Regional Facilities Director and the Maintenance Director on 10/26/23 at 12:34 p.m., the kitchen was provided	K 0324	K – 324 – Cooking Facilities 1 The deficient practice has the potential to affect all residents in the facility. The Director of Plant Operations has educated all dietary staff on the location of the pull station for the UL 300 hood system, along with when and how to use the suppression system. According to NFPA 96, 11.1.4. 2 Facility staff have been educated on the location of the UL 300 hood system pull station and the purpose of the suppression	11/10/2023

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	with a UL 300 hood system and a K-class fire extinguisher with posted instructions. Based on interview, the Cook was asked how to activate the hood suppression system if there was a grease fire underneath the hood. The Cook did not know where the pull station to activate the suppression system was located. The Maintenance Director acknowledged the Cooks response and stated staff will need to be trained on the proper procedures for extinguishing a grease fire on the cooking equipment. This finding was reviewed with the Maintenance Director and the Regional Facilities Director at the exit conference. 3.1-19(b)		system. 3 The DPO or designee will audit staff within the campus weekly for six weeks to ensure staff is aware of the pull station location. 4 As a quality measure, the DPO or designee will review any findings and corrective action monthly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. Compliance date of November 10, 2023.	
K 0345 SS=F Bldg. 02	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 18.3 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in	K 0345	K – 345 – Fire Alarm System 1 The deficient practice has the potential to affect all residents in the facility. The Director of Plant Operations has been educated on	11/10/2023

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	accordance with the schedules in Table 14.3.1, or more often if required by the authority having 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 affects all occupants in the facility. Findings include: During records review with the Regional Facilities Director and the Maintenance Director on 10/26/23 at 10:05 a.m., no documentation was provided regarding a visual inspection of the fire alarm system six months after the annual fire alarm inspection conducted on 01/09/23. Based on interview at the time of records review, the Maintenance Director stated a visual inspection of the fire alarm system six months after the annual fire alarm inspection was not conducted. This finding was reviewed with the Maintenance Director and the Regional Facilities Director at the exit conference. 3.1-19(b)		proper inspection and documentation of the Fire Alarm System. According to NFPS 72 as required by LSC 101 sections 18.3 and 9.6. NFPA 72 section 14.3.1, 14.3.2, and Table 14.3.1. 2 The Director of Plant Operations has been educated by the Executive Director regarding facility policy and state regulations regarding inspection and documentation of Fire Alarm System. 3 The ED will audit the inspections of the Fire Alarm system every six months. 4 As a quality measure, the DPO or designee will review any findings and corrective action monthly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. Compliance date of November 10, 2023.	
K 0351 SS=E Bldg. 02	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 NEW Buildings are to be protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the			

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	155495	A. BUILDING 02 B. WING	10/26/2023

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	Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state and local regulations prohibit sprinklers. Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed six square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 18.3.5.1, 18.3.5.4, 18.3.5.5, 18.3.5.6, 9.7, 9.7.1.1(1), 18.3.5.10 #1) Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 6 smoke compartments in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. This deficient practice could affect staff and up to 20 residents in one smoke compartment. Findings include: Based on observations with the Regional Facilities Director and the Maintenance Director on 10/26/23 at 12:00 p.m., in the kitchen there was a missing sprinkler head escutcheon above the prep table. Based on interview at the time of observation, the Maintenance Director agreed there was a sprinkler in the kitchen that was missing an escutcheon.	K 0351	K – 351 – Sprinkler System 1 The deficient practice has the potential to affect all residents in the facility. The Director of Plant Operations has replaced the missing sprinkler head in the kitchen. The Director of Plant Operations has put up new signs identifying the location of the Fire Department Connection that are visible from the road. According to NFPA 13, 2010 Edition, section 6.2.7.1 and NFPA 25, 2011 Edition section 13.7.1. 2 The DPO was educated by the Executive Director regarding the regulatory requirements for inspection and replacement for sprinkler heads and for appropriate directional signage and visibility of the Fire Department signs.	11/10/2023

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	#2) Based on observation and interview, the facility did not provide adequate signage for 1 of 1 fire department connection (FDC). NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, 13.7 Fire Department Connections. 13.7.1 Fire department connections shall be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. This deficient practice could affect all residents. Findings include: Based on observation with the Regional Facilities Director and the Maintenance Director on 10/26/23 at 12:18 p.m., the FDC was located at the rear of the building not visible from the main roadway. There was no directional signage on the property leading to the FDC. Based on interview at the time of observation, the Maintenance Director agreed the FDC was on the side of the building that was not visible from the road and there were no signs indicating the FDC location. This finding was reviewed with the Maintenance Director and the Regional Facilities Director at the exit conference.		3 The DPO or designee will audit the sprinkler heads throughout the campus weekly for six weeks. The DPO or designee will audit the signs monthly during routine audits for six months. 4 As a quality measure, the DPO or designee will review any findings and corrective action monthly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. Compliance date of November 10, 2023.	

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	3.1-19(b)			
K 0353 SS=E Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation, and interview; the facility failed to ensure 1 of 1 sprinkler heads behind the Laundry room dryers covered with lint were replaced or cleaned in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states 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	K 0353	K – 353 – Sprinkler System 1 The deficient practice has the potential to affect all residents in the facility. The Director of Plant Operations has cleaned the sprinkler head with lint present and checked all other sprinkler heads within the campus. According to NFPA 25, 2011 Edition, Section 5.2.1.1.1 and Section 5.2.1.1.2. 2 Facility staff have been educated on notifying the DPO if they notice any sprinkler head that has any debris. 3 The DPO or designee will	11/10/2023

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	(4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect two staff in the Laundry room. Findings include: Based on observation with the Regional Facilities Director and the Maintenance Director on 10/26/23 at 12:40 p.m. the one sprinkler located by the washers was covered with lint. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned automatic sprinkler was loaded with lint. This finding was reviewed with the Maintenance Director and the Regional Facilities Director at the exit conference. 3.1-19(b)		audit the sprinkler heads weekly for six weeks to ensure there are no sprinkler heads with noticeable debris. 4 As a quality measure, the DPO or designee will review any findings and corrective action monthly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. Compliance date of November 10, 2023.	
K 0511 SS=C Bldg. 02	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on record review and interview the facility failed to ensure that the emergency generator had	K 0511	K – 511 – Utilities – Gas and Electric	11/10/2023

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	a reliable source of fuel in accordance with the requirements of LSC 18.5.1.1 and NFPA 110, 2010 Edition, 5.1. LSC Section 9.1.3.1 states emergency generators shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. A.5.1.1 states examples of probability of interruption could include the following: earthquake, flood damage, or a demonstrated utility unreliability. This deficient practice had the potential to affect all residents. Findings include: Based on observation with the Regional Facilities Director and the Maintenance Director on 10/26/23 at 10:39 a.m., no letter from the provider's natural gas company was available to show the reliability of the natural gas supply. Based on interview during records review, the Maintenance Director stated the reliability letter could not be found. This finding was reviewed with the Maintenance		1 The deficient practice has the potential to affect all residents in the facility. The Director of Plant Operations has acquired the appropriate documentation from the natural gas company to show reliability of the natural gas supply. According to LSC 18.5.1.1 and NFPA 110, 2010 Edition 5.1. 2 The Director of Plant Operations has been educated on ensuring the campus has appropriate letters for reliability of resources for the campus. 3 The ED or designee will audit the campus reliability letters semiannually for updated and appropriate resource availability. 4 As a quality measure, the DPO or designee will review any findings and corrective action monthly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. Compliance date of November 10, 2023.	

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	Director and the Regional Facilities Director at the exit conference. 3.1-19(b)			
K 0932 SS=E Bldg. 02	NFPA 101 Features of Fire Protection - Other Features of Fire Protection - Other List in the REMARKS section any NFPA 99 Chapter 15 Features of Fire Protection requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 15 (NFPA 99) Based on observation and interview the facility failed to ensure 1 of 1 locations was not used for the storage of flammable liquids. NFPA 99 15.3.2 states no storage or handling of flammable liquids or gases shall be permitted in any location where such storage would jeopardize egress from the structure, unless otherwise permitted by 15.3.1. This deficient practice could affect 15 residents in the 400-hall. Findings include: Based on observation with the Regional Facilities Director and the Maintenance Director on 10/26/23 at 11:23 a.m., the 400-hall janitor closet was being used for storage of 15 highly flammable (according to the product information) aerosol cans. The corridor door to the room was not fire-rated, the walls were not rated as a one-hour fire barrier, and such storage could jeopardize safe egress through the 400 hall. Based on interview at the time of observation, the Maintenance Director agreed there were flammable liquids stored in the closet and stated there was no fire-rating on the	K 0932	K – 932 – Features of Fire Protection 1 The deficient practice has the potential to affect all residents residing on 400 hall. The Director of Plant Operations has removed all flammable materials from the janitor supply closet and placed them in the appropriate flammable cabinet. According to NFPA 99 15.3.2. 2 Facility staff have been educated on storing flammable materials in any areas of the facility without hazardous protection. 3 The DPO or designee will audit the janitor and supply closets to ensure no inappropriate products are being stored in them weekly for six weeks. 4 As a quality measure, the DPO or designee will review any	11/10/2023

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	door and according to the construction plans the room was not a one-hour fire rated room. This finding was reviewed with the Maintenance Director and the Regional Facilities Director at the exit conference. 3.1-19(b)		findings and corrective action monthly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. Compliance date of November 10, 2023.	