STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING -- B. WING	03/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW CROSSING HEALTH & REHABILITATION CENTER	3550 CENTRAL AVE COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/10/25 Facility Number: 000572 Provider Number: 155535 AIM Number: 100267710 At this Emergency Preparedness survey, Willow Crossing Health & Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 112 certified beds. At the time of the survey, the census was 93. Quality Review completed on 03/12/25	E 0000	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the Statement of Deficiencies. The Plan of Correction is prepared and submitted because of the requirement under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance. Please find enclosed this Plan of Correction for this survey. Due to the low scope and severity of the survey findings, please find the sufficient documentation providing evidence of compliance with the Plan of Correction. The documentation serves to confirm the Community's allegation of compliance. Thus, the community respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance feel free to contact me.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).	K 0000	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth of facts	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alisha Miller	Administrator	03/24/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING 01 B. WING	03/10/2025

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	Survey Date: 03/10/25 Facility Number: 000572 Provider Number: 155535 AIM Number: 100267710 At this Life Safety Code survey, Willow Crossing Health & Rehabilitation Center was found not in compliance with Requirements for Participation 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 consists of two buildings. Building 01, the original building, was determined to be of Type V (111) construction and was fully sprinklered. Building 02, the New Wing addition added to the west end of the original building in 2022, was determined to be of Type V(111) construction and was fully sprinklered. Building 02 consists of new occupational & physical therapy rooms and a 32-bed locked unit in the new 300 Hall. Building 01 was surveyed with Chapter 19, Existing Health Care Occupancies. Building 01 has a fire alarm system with smoke detection in the corridors, in all areas open to corridor and hard-wired smoke detectors in all resident rooms. The facility has a capacity of 112 and had a census of 93 at the time of the survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 03/12/25		alleged or correction set forth on the Statement of Deficiencies. The Plan of Correction is prepared and submitted because of the requirement under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance. Please find enclosed this Plan of Correction for this survey. Due to the low scope and severity of the survey findings, please find the sufficient documentation providing evidence of compliance with the Plan of Correction. The documentation serves to confirm the Community's allegation of compliance. Thus, the community respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance feel free to contact me.	

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	155535	A. BUILDING 01 B. WING	03/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW CROSSING HEALTH & REHABILITATION CENTER	3550 CENTRAL AVE COLUMBUS, IN 47203

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K 0100 SS=C Bldg. 01	NFPA 101 General Requirements - Other Based on observation and interview, the facility failed to remove 1 of 2 essential electric system alarm remote annunciators which was in a location readily observed by operating personnel. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor and the Corporate Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:00 p.m. on 03/10/25, one of one remote annunciator panels located at the nurse's station at the main entrance lobby for the facility's emergency generator had no electrical power and its warning lights failed to illuminate when its test button was depressed multiple times. Based on interview at the time of the observations, the Corporate Maintenance Supervisor stated the annunciator panel was inoperable. The Corporate Maintenance Supervisor stated the facility replaced its emergency generator within the last few years and replaced the main entrance lobby nurse's station remote annunciator panel with a new annunciator panel located at the 300 Hall nurse's station. Based on interview at the time of the observations, the Corporate Maintenance Supervisor agreed the remote annunciator panel at the main entrance lobby nurse's station had no electrical power and should be removed. These findings were reviewed with the Director of Nursing, the Maintenance Supervisor and the	K 0100	1 No residents, staff, or visitors were affected. On 03/18/25 the remote annunciator panel without electricity at the main entrance lobby nurse's station has been removed. (Attachment C) 2 All residents, staff, or visitors have the potential to be affected by the deficient practice; thus the following corrective actions have been taken: 3 As a means of ongoing compliance the Maintenance Director has been educated in regards to existing life safety features shall either be maintained or removed. (Attachment A) 4 As a means of quality assurance, the Maintenance Director or designee will review all existing life safety features initially, then monthly thereafter to ensure that they are maintained and if not maintained, then removed. The results of the audits will be reviewed as part of the monthly quality assurance meeting with the plan of action adjusted accordingly, as warranted. (Attachment H) 5 The above corrective action will be completed by 03/18/2025	03/18/2025

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	Corporate Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 2 closets in the Library in accordance with LSC 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in Section 8.5.5.2 and Section 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Library. Findings include: Based on observations with the Maintenance Supervisor and the Corporate Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:00 p.m. on 03/10/25, one of the two closets in the Library had box storage on shelving within twelve inches of the ceiling mounted sprinkler in the closet. The back wall of the closet was part of the north wall of the adjoining resident sleeping Room 114. Based on interview at the time of the observations, the Maintenance Supervisor and the Corporate Maintenance Supervisor agreed box storage in the closet was	K 0351	1 No residents, staff, or visitors were affected. On 03/18/2025 the box storage on shelving within 12" of the ceiling mounted sprinkler in the closet was removed. (Attachment E) 2 All residents, staff, or visitors have the potential to be affected; thus the following corrective action has been taken; 3 As a means of ongoing compliance, the facility maintenance director has been re-educated on not obstructing the spray pattern of a sprinkler head. (Attachment A). 4 As a means of quality assurance, the maintenance/ director or designee will audit sprinkler heads for obstructions weekly for four weeks, then monthly thereafter. (Attachment D) Any concerns will be brought to the attention of the Administrator and will be addressed immediately. The results of the audits will be reviewed as part of the monthly quality assurance meeting with the plan of action adjusted accordingly, as warranted. 5 The above corrective action	03/18/2025

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	within 18 inches of the sprinkler deflector in the closet. These findings were reviewed with the Director of Nursing, the Maintenance Supervisor and the Corporate Maintenance Supervisor during the exit conference. 3.1-19(b)		will be completed by 03/18/25	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to ensure 1 of 11 portable fire extinguishers were installed in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than five feet above the floor. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Therapy Storage room by the sprinkler riser room. Findings include: Based on observations with the Maintenance Supervisor and the Corporate Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:00 p.m. on 03/10/25, the ABC type portable fire extinguisher located in the Therapy Storage room by the sprinkler riser room was mounted on the wall with the top of the extinguisher 72 inches above the floor. Based on interview at the time of the observations, the Maintenance Supervisor and the Corporate Maintenance Supervisor agreed the aforementioned portable fire extinguisher was	K 0355	1 No residents, staff, or visitors were affected. The fire extinguisher was lowered on 03/18/25 so that the top of it is within five feet of the floor. (Attachment F) 2 All residents, staff, or visitors have the potential to be affected. Thus the following corrective actions have been taken: 3 The maintenance director has been educated on the top of a fire extinguisher cannot be more than five feet from the floor. (Attachment G) 4 As a means of quality assurance, the maintenance director or designee will review all fire extinguishers as part of the preventative maintenance program to ensure that an inspection has been completed at least monthly (see attachment H). The results of the audit will be reviewed as part of the monthly quality assurance meeting with a plan of action	03/18/2025

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	mounted on the wall with the top of the extinguisher greater than five feet above the floor. These findings were reviewed with the Director of Nursing, the Maintenance Supervisor and the Corporate Maintenance Supervisor during the exit conference. 3.1-19(b)		adjusted accordingly, as warranted. 5 The above corrective action will be completed by 03/18/25	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on observation and interview, the facility failed to ensure overcurrent protective devices in Emergency Power Supply Systems (EPSS) circuits were accessible only to authorized persons. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Section 6.5.4 states overcurrent devices in EPSS circuits shall be accessible to authorized persons only. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor and the Corporate Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:00 p.m. on 03/10/25, two of two emergency generator transfer switches located outside the facility on the north side of the building outside the main dining room for Building 01 were in an unlocked detached weatherproof storage cabinet. Based on interview at the time of the observations, the Maintenance Supervisor and the Corporate Maintenance Supervisor agreed each of the two emergency generator transfer switches was in an unlocked detached weatherproof storage cabinet outside the facility.	K 0918	1 No residents, staff, or visitors were affected. On 03/18/2025 locks have been placed on the two emergency generator switches. (Attachment I and J) 2 All residents, staff, or visitors have the potential to be affected thus the following corrective action has been taken; 3 The maintenance director has been educated on ensuring that over current protective devices in EPSS circuits were accessible only to authorized personnel. (Attachment G). 4 As a means of quality assurance, the maintenance director or designee will conduct a monthly audit of over current protective devices (Attachment H) to ensure that over current protective devices in EPSS circuits were accessible only to authorized persons. Any concerns will be brought to the administrator and fixed immediately. The results	03/18/2025

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	These findings were reviewed with the Director of Nursing, the Maintenance Supervisor and the Corporate Maintenance Supervisor during the exit conference. 3.1-19(b)		of the audits will be reviewed as part of the monthly quality assurance meeting with the plan of action adjusted accordingly, as warranted. 5 The above corrective action will be completed by 03/18/25.	
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 all Patient Care Related Electrical Equipment (PCREE). NFPA 99, Health Care Facilities Code, 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing,	K 0921	1 No residents, staff, or visitors were affected. On 03/21/2025 inspections for all PCREE was completed. (Attachment L) 2 All residents, staff, or visitors have the potential to be affected; thus the following corrective actions have been taken: 3 The maintenance director has been educated to ensure that all PCREE is tested prior to being put into use and after any repair or modification. (Attachment B) 4 As a means of Quality Assurance, the maintenance director or designee will audit the PCREE in 10 resident rooms monthly ensuring that it has been inspected. (Attachment H) The results of the audits will be reviewed as part of the monthly quality assurance meeting with the plan of action adjusted accordingly, as warranted. 5 The above corrective action will be completed by 03/21/25.	03/21/2025

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	maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents in the facility. Findings include: Based on review of "SAFE-TEST 50 Electrical Safety Analyzer Bed-Test NFPA 99" documentation dated 01/10/25 with the Maintenance Supervisor and the Corporate Maintenance Supervisor during record review from 9:30 a.m. to 12:30 p.m. on 03/10/25, PCREE testing documentation for the facility only included resident sleeping room beds. Additional PCREE testing documentation was not available for review. Based on interview at the time of record review, the Corporate Maintenance Supervisor agreed additional PCREE testing documentation, other than that conducted for resident sleeping room beds, was not available for review at the time of the survey. Based on observations with the Maintenance Supervisor and the Corporate Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:00 p.m. on 03/10/25, a nebulizer was noted in resident sleeping Room 202 and oxygen concentrators were stored in the oxygen storage and transfilling room. These findings were reviewed with the Director of Nursing, the Maintenance Supervisor and the Corporate Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0930 SS=A Bldg. 01	NFPA 101 Gas Equipment - Liguid Oxygen Equipment Based on observation and interview, the facility	K 0930	No plan of correction is required.	03/18/2025

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	failed to protect 6 of over 40 resident rooms from the use of liquid oxygen containers stored in a patient bed location or patient care room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.7.4 states the maximum total quantity of liquid oxygen permitted in storage and in use in a patient bed location or patient care room shall be 120 L (31.6 gallons), provided that the patient bed location or patient care room, or both, are separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour in accordance with the adopted building code. LSC Section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. This deficient practice could affect 6 residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor and the Corporate Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:00 p.m. on 03/10/25, one liquid oxygen container was stored and in use in resident sleeping Room 102, 103, 110, 202, 207 and 220. Each of the six resident sleeping rooms were not separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour. The corridor door to the rooms was not self-closing or automatic closing and each door was not equipped with a fire resistance rating label affixed to the door. Based on interview at the time of the observations, the Maintenance Supervisor and the Corporate Maintenance Supervisor agreed liquid oxygen containers were stored and in use in the rooms and each room was not maintained with a minimum fire resistance rating of 1 hour.			

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	These findings were reviewed with the Director of Nursing, the Maintenance Supervisor and the Corporate Maintenance Supervisor during the exit conference.			
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/10/25 Facility Number: 000572 Provider Number: 155535 AIM Number: 100267710 At this Life Safety Code survey, Willow Crossing Health & Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare, 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 consists of two buildings. Building 01, the original building, was determined to be of Type V (111) construction and was fully sprinklered. Building 02, the New Wing addition added to the west end of the original building in 2022, was determined to be of Type V(111) construction and was fully sprinklered. Building 02 consists of new occupational & physical therapy rooms and a 32-bed locked unit in the new 300 Hall. Building 02 was surveyed with Chapter 18, New Health Care Occupancies.	K 0000	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the Statement of Deficiencies. The Plan of Correction is prepared and submitted because of the requirement under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance. Please find enclosed this Plan of Correction for this survey. Due to the low scope and severity of the survey findings, please find the sufficient documentation providing evidence of compliance with the Plan of Correction. The documentation serves to confirm the Community's allegation of compliance. Thus, the community respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance feel free to contact me.	

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	Building 02 has a fire alarm system with smoke detection in the corridors and in all areas open to corridor. Building 02 has smoke detectors connected to the building electrical system in the new 300 Hall resident sleeping rooms with battery backup which report to the 300 Hall nurse's station. The facility has a capacity of 112 and had a census of 93 at the time of the survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 03/12/25			
K 0293 SS=E Bldg. 02	NFPA 101 Exit Signage Based on observation and interview, the facility failed to ensure 1 of 1 door sets to the outside of the facility in the 300 Hall Activity Room was not mistaken as a facility exit. LSC Section 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect over 10 residents, staff and visitors in the 300 Hall Activity Room. Findings include: Based on observations with the Maintenance Supervisor and the Corporate Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:00 p.m. on 03/10/25, the exit door to the	K 0293	1 No residents, staff, or visitors were affected. On 03/18/25 a “Not an Exit” sign was placed on the door to the outside of the facility in the 300 hall activity room. (Attachment K) 2 All residents, staff and visitors have the potential to be affected, thus the following corrective actions have been taken: 3 The maintenance director has been educated that all exit and directional signs are displayed in accordance with 7.10 (see attachment B). 4 As a means of quality assurance, the maintenance director or designee will audit all exit signage monthly as part of the preventative maintenance program. (Attachment H). The results of the	03/18/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW CROSSING HEALTH & REHABILITATION CENTER	3550 CENTRAL AVE COLUMBUS, IN 47203

(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
	outside of the facility in the 300 Hall Activity Room was not marked as a facility exit with an exit sign. The exit door was also not equipped with signage affixed to the door stating it was "Not an Exit". The exit discharge for the 300 Hall Activity Room was a gated courtyard with one magnetically secured gate which required a code at a keypad to release the gate to open. The code was not posted because the 300 Hall is a dedicated wing for residents with the clinical diagnosis to be in a secure wing. Based on interview at the time of the observations, the Maintenance Supervisor and the Corporate Maintenance Supervisor stated they were not certain the door was an exit door or not an exit door but agreed the door was not currently marked as a facility exit with an exit sign and was also not currently marked as not an exit. These findings were reviewed with the Director of Nursing, the Maintenance Supervisor and the Corporate Maintenance Supervisor during the exit conference. 3.1-19(b)		audit will be reviewed as part of the monthly quality assurance meeting with a plan of action adjusted accordingly, as warranted. 5 The above corrective action will be completed by 03/18/2025.	
K 0921 SS=F Bldg. 02	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 all Patient Care Related Electrical Equipment (PCREE). NFPA 99, Health Care Facilities Code, 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	K 0921	1 No residents, staff, or visitors were affected. On 03/21/2025 inspections for all PCREE was completed. (Attachment L) 2 All residents, staff, or visitors have the potential to be affected; thus the following corrective actions have been taken: 3 The maintenance director	03/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING 02 B. WING	03/10/2025

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	patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents in the facility. Findings include: Based on review of "SAFE-TEST 50 Electrical Safety Analyzer Bed-Test NFPA 99" documentation dated 01/10/25 with the Maintenance Supervisor and the Corporate Maintenance Supervisor during record review from 9:30 a.m. to 12:30 p.m. on 03/10/25, PCREE testing documentation for the facility only included resident sleeping room beds. Additional PCREE testing documentation was not available for review. Based on interview at the time of record review, the Corporate Maintenance Supervisor agreed additional PCREE testing documentation, other than that conducted for resident sleeping room beds, was not available for review at the time of the survey. Based on observations with the Maintenance Supervisor		has been educated to ensure that all PCREE is tested prior to being put into use and after any repair or modification. (Attachment B) 4 As a means of Quality Assurance, the maintenance director or designee will audit the PCREE in 10 resident rooms monthly ensuring that it has been inspected. (Attachment H) The results of the audits will be reviewed as part of the monthly quality assurance meeting with the plan of action adjusted accordingly, as warranted. 5 The above corrective action will be completed by 03/21/25.	

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	155535	A. BUILDING 02 B. WING	03/10/2025

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	and the Corporate Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:00 p.m. on 03/10/25, a nebulizer was noted in resident sleeping Room 202 and oxygen concentrators were stored in the oxygen storage and transfilling room. These findings were reviewed with the Director of Nursing, the Maintenance Supervisor and the Corporate Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0930 SS=A Bldg. 02	NFPA 101 Gas Equipment - Liguid Oxygen Equipment Based on observation and interview, the facility failed to protect 2 of 16 resident rooms from the use of liquid oxygen containers stored in a patient bed location or patient care room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.7.4 states the maximum total quantity of liquid oxygen permitted in storage and in use in a patient bed location or patient care room shall be 120 L (31.6 gallons), provided that the patient bed location or patient care room, or both, are separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour in accordance with the adopted building code. LSC Section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. This deficient practice could affect 2 residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor and the Corporate Maintenance	K 0930	No plan of correction is required.	03/18/2025

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	155535	A. BUILDING 02 B. WING	03/10/2025

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	Supervisor during a tour of the facility from 12:30 p.m. to 2:00 p.m. on 03/10/25, one liquid oxygen container was stored and in use in resident sleeping Room 305 and 308. Each of the two resident sleeping rooms were not separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour. The corridor door to the rooms was not self-closing or automatic closing and each door was not equipped with a fire resistance rating label affixed to the door. Based on interview at the time of the observations, the Maintenance Supervisor and the Corporate Maintenance Supervisor agreed liquid oxygen containers were stored and in use in the rooms and each room was not maintained with a minimum fire resistance rating of 1 hour. These findings were reviewed with the Director of Nursing, the Maintenance Supervisor and the Corporate Maintenance Supervisor during the exit conference.			