STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155171	A. BUILDING -- B. WING	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRANKLIN MEADOWS	1285 W JEFFERSON ST FRANKLIN, IN 46131

(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: 01/05/23 Facility Number: 000087 Provider Number: 155171 AIM Number: 100289890 At this Emergency Preparedness survey, Franklin Meadows was found 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 80. Quality Review completed on 01/09/23	E 0000	**This plan of correction is to serve as Franklin Meadows credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Franklin Meadows or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.** **We would like to respectfully request paper compliance for Franklin Meadows Life Safety Code Recertification and Emergency Preparedness Survey.**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/05/23 Facility Number: 000087 Provider Number: 155171	K 0000	**This plan of correction is to serve as Franklin Meadows credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Franklin Meadows or its management company that the allegations**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jason Kennedy		01/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	AIM Number: 100289890 At this Life Safety Code Survey, Franklin Meadows was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. Battery operated smoke detectors are installed in all resident sleeping rooms. The facility has a capacity of 114 and had a census of 80 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except three detached wooden sheds providing facility storage. Quality Review completed on 01/09/23		**contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.** **We would like to respectfully request paper compliance for Franklin Meadows Life Safety Code Recertification and Emergency Preparedness Survey.**	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 7 means of egress was	K 0211	**K211 Means of Egress**	02/03/2023

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	continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 12:20 p.m. to 1:45 p.m. on 01/05/23, the exit door for the south hall was marked as a facility exit with an exit sign. The south hall exit discharges into a vestibule which was being used as a conference room which had an exit door to the outside of the facility which was a delayed egress door equipped with the necessary signage. A conference room chair was placed directly in the path of egress to the delayed egress door which did not ensure this means of egress was continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned means of egress was not continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency and moved the chair out of the path of egress. This finding was reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		I. The conference chair was immediately moved to abstain from obstructing the path of egress. II. Residents and staff have the potential to be affected by the alleged deficient practice. A walkthrough was done throughout the building to ensure that all egresses were unobstructed, any discrepancies were corrected immediately. III. Education will be provided to all staff regarding all egresses being continuously maintained free of all obstructions or impediments to full instant use in case of emergency. IV. The Maintenance Director/Designee will provide walking round audits on the building to ensure all egresses are unobstructed, if any objects are found they will be moved immediately. This audit will happen daily for four weeks; then, weekly thereafter totaling 12 months. **Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed** **V. Plan of Correction**	

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			completion date. Date of Compliance: 02/03/2023 The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation and interview, the facility failed to meet the clear width requirement for 2 of 7 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 feet.	K 0232	**K-232** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- The community failed to meet the clear width requirement for 2 of 7 corridors. The Maintenance Supervisor removed two wooden chairs from the corridors that were creating obstructions. **II. The facility will identify other residents that may potentially be affected by the deficient practice.**	02/03/2023

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	(f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 12:20 p.m. to 1:45 p.m. on 01/05/23, a wooden chair was stored in the corridor outside Room 113 in the A Hall and in the corridor outside Room 153 in the D Hall. Each chair extended two feet into the eight foot wide corridor and the chairs were not affixed to the floor or to the wall. Based on interview at the time of the observations, the Maintenance Director agreed furniture was stored in the corridor at the aforementioned two locations which was not affixed to the floor or to the wall. This finding was reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		Resident and Staff in the community could be affected by this deficiency. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Staff Development Coordinator will educate all staff on the importance of not obstructing corridors. New TELS task was created for Maintenance Supervisor to monitor hallways weekly for obstructions. **IV The facility will monitor the corrective action by implementing the following measures.** Maintenance Supervisor, or designee, will monitor and inspect all corridors during annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is 2/3/2023.	

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K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 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. 1. Based on observation and interview, the facility failed to replace battery operated smoke alarms installed in 3 of 4 Halls housing resident sleeping rooms in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 12:20 p.m. to 1:45 p.m. on 01/05/23, manufacturer's documentation affixed to the First Alert Model SA 340 battery operated smoke alarm installed on the ceiling in resident sleeping Room 102 in the A Hall indicated the smoke alarm was manufactured 10/27/11. An installation date of 02/01/12 was written on the back of the smoke alarm. The same type of smoke detector was installed in all resident sleeping rooms in the A, B and C Halls. Based on interview at the time of the observations, the Maintenance Director and the	K 0300	**K-300** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- The facility failed to replace battery operated smoke alarms in 3 of 4 halls housing resident sleeping rooms in accordance with NFPA 72. The Maintenance Supervisor replaced all smoke detectors on affected halls. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Resident and Staff in the community could be affected by this deficiency. **III. The facility will put into place the following systematic changes to ensure that the**	02/03/2023

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	Field Maintenance Supervisor stated each resident sleeping room in the A, B and C Halls has the same type of battery operated smoke alarm installed in the room and agreed resident sleeping room battery operated smoke alarms installed in 3 of 4 Halls housing resident sleeping rooms in facility were more than ten years old. This finding was reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to ensure documentation for the preventative maintenance of all battery operated smoke alarms in resident rooms was complete. 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, National Fire Alarm and Signaling Code, 2010 Edition, 29.10 Maintenance and Tests states 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, staff, and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during record review from 9:00 a.m. to		**deficient practice does not recur.** TELS task was created for Maintenance Supervisor to inspect smoke alarms monthly. **IV The facility will monitor the corrective action by implementing the following measures.** Maintenance Supervisor, or designee, will monitor and inspect all battery-operated smoke alarms during annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is 2/3/2023	

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	12:20 p.m. on 01/05/23, battery operated smoke detector cleaning documentation for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated the facility cleans the battery operated smoke detectors during each monthly test but agreed an itemized list of each battery operated smoke detector cleaned within the most recent twelve month period was not available for review. Based on observations with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 12:20 p.m. to 1:45 p.m. on 01/05/23, manufacturer's documentation affixed to the First Alert Model SA 340 battery operated smoke alarm installed on the ceiling in resident sleeping Room 102 in the A Hall stated to clean the unit monthly. Based on interview at the time of the observations, the Maintenance Director and the Field Maintenance Supervisor stated each resident sleeping room in the A, B and C Halls has the same type of battery operated smoke alarm installed in the room. Manufacturer's documentation affixed to the Kidde Model i9010 battery operated smoke alarm installed on the ceiling in resident sleeping Room 150 in the D Hall stated to clean the unit annually. This finding was reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating			

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	(with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 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 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of over 9 hazardous areas such as combustible storage areas (over 50 square feet in size) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Nursing Supply Room by the corridor door set to the A Hall.	K 0321	**K-321** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- The facility failed to ensure 1 of over 9 hazardous	02/03/2023

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	Findings include: Based on observations with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 12:20 p.m. to 1:45 p.m. on 01/05/23, the latching plate on the door frame for the corridor door to the Nursing Supply Room by the corridor door set to the A Hall was missing which caused a one inch gap in between the face of the door and the door stop on the handle side of the door when the door was in the fully closed and latched position. The gap would not resist the passage of smoke. The Nursing Supply Room was greater than 50 square feet in size and was used as a storage room for combustible boxes and supplies. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned hazardous area was not separated from other spaces by smoke resistant partitions and doors. This finding was reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		areas such as combustible storage areas were separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Maintenance Supervisor replaced latching plate on hazardous area that would not close properly. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Resident and Staff in the community could be affected by this deficiency. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** SDC to educate staff on the importance of notifying maintenance if doors are not latching. Monthly TELS task was created for Maintenance Supervisor to ensure doors to hazardous areas close properly. **IV The facility will monitor the corrective action by implementing the following measures.**	

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			Maintenance Supervisor, or designee, will monitor and inspect all doors to hazardous areas during annual CQR. Door Inspection QI tool will be completed weekly for 6 weeks and then monthly for a total of 12 months. **V. Plan of Correction completion date.** Plan of Completion date is 2/3/2023.	
K 0331 SS=F Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). Based on record review, observation and interview; the facility failed to ensure 1 of 6 corridors and 2 of 2 dining rooms were provided with a complete interior finish with a flame spread rating of Class A or Class B for a sprinklered facility. LSC 10.2.3.4 states products required to be tested in accordance with ASTM E 84, Standard Test Method for Surface Burning Characteristics of Building Materials or ANSI/UL 723, Standard for Test for Surface Burning Characteristics of Building Materials shall be	K 0331	**K331 Interior Wall and Ceiling Finish** I. The facility has failed to ensure 1 of 6 corridors and 2 of 2 dining rooms were provided with a complete interior finish with a flame spread rating a minimum of Class B. The maintenance supervisor contacted Underwood Construction to get the laminated	02/03/2023

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	grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor from 9:00 a.m. to 12:20 p.m. on 01/05/23, flame spread rating documentation for interior finishes installed in the facility was not available for review. Based on observations with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 12:20 p.m. to 1:45 p.m. on 01/05/23, a laminate finish was installed on the C Hall corridor walls below the handrails. Wood was also affixed to a wall of the C Hall dining room to create a large sign board in the dining room. The C Hall dining room was open to the corridor. In addition, a laminate finish was installed below the wall trim on all walls of the main dining room. The main dining room was also		finishes removed. Underwood Construction will be back 1/27/23 to complete. II. Residents and staff have the potential to be affected by the alleged deficient practice. All corridors and dining rooms were inspected to ensure correct fire rating was provided and documented. III. Educated was provided to the maintenance department regarding proper flame spread rating. IV. The maintenance director/designee will ensure each corridor and dining room is audited during the annual review. **Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed** **V. Plan of Correction completion date.** Date of Compliance: 02/03/2023 The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRANKLIN MEADOWS	1285 W JEFFERSON ST FRANKLIN, IN 46131

(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
	open to the corridor. Based on interview at the time of the observations, the Field Maintenance Supervisor stated flame spread rating documentation for the laminate interior finish and wood sign board in the C Hall dining room was not available for review, the laminate wall finish was not treated with flame retardant material and stated the laminate interior finish was due to be removed from the walls. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, observation and interview; the facility failed to maintain automatic	K 0353	**K-353**	02/03/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155171	A. BUILDING 01 B. WING	01/05/2023

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FRANKLIN MEADOWS	1285 W JEFFERSON ST FRANKLIN, IN 46131

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	sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the sprinkler system inspection contractor's "Form for Inspection, Testing and Maintenance of Wet Pipe Fire Sprinkler Systems" documentation dated 03/21/22 with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during record review from 9:00 a.m. to 12:20 p.m. on 01/05/23, numerous deficiencies were noted during the contractor's annual sprinkler system inspection. The "Deficiency Summary" section of the 03/21/22 report included many different deficiencies which included "missing (2) chrome 200 FR uprights" spare sprinklers, corroded and painted sprinkler head locations including the closets in Room 108 and Room 140, corroded and missing escutcheon locations, locations where there are gaps in between sprinkler escutcheons and ceiling tiles, sprinkler head locations are too		**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- The facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. A contractor has made all required repairs from the previous *"Form for Inspection. Testing and Maintenance of Wet Pipe Fire Sprinkler Systems " documentation dated 03/21/22 of multiple deficiencies*. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Resident and Staff in the community could be affected by this deficiency. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Monthly TELS task was created for Maintenance Supervisor to inspect automatic sprinkler systems. **IV The facility will monitor the corrective action by**	

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	long or too short, two sprinkler head locations in the laundry are installed less than six feet apart and the sprinkler head in the storage room by the oxygen room is hanging three inches below the ceiling tile. Based on interview at the time of record review, the Maintenance Director stated he was not aware if any specific deficiency from the 03/21/22 inspection has been corrected, the facility had been working with the contractor to get the deficiencies corrected but agreed repair or replace documentation to correct the 03/21/22 sprinkler system annual inspection deficiencies was not available for review at the time of record review. The Maintenance Director supplied an e-mail document dated 1:17 p.m. on 01/05/23 from the sprinkler system inspection contractor stating "We have a tech coming today to get a better look at the situation and get a material list. This is on the schedule for Monday, January 09. Not sure if it will be completed in (1) day but we should have it all done by the end of next week." Based on observations with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 12:20 p.m. to 1:45 p.m. on 01/05/23, the sprinkler locations in the closet for Room 108 and Room 140 were painted. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		**implementing the following measures.** Maintenance Supervisor, or designee, will monitor and inspect automatic sprinkler systems during annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is 2/3/2023.	