STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155355	A. BUILDING -- B. WING	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEST BEND NURSING AND REHABILITATION	4600 W WASHINGTON AVE SOUTH BEND, IN 46619

(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: 01/06/2025 Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420 At this Emergency Preparedness survey, West Bend Nursing and Rehabilitation was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 157 and had a census of 57 at the time of this survey. Quality Review completed on 01/08/25	E 0000	**K000** The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after 2/4/2025.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt	E 0039	**E0039** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Facility implemented Emergency Preparedness Plan on January 13, 2025, from actual emergency event. Executive Director completed an after-action analysis. 2. How other residents having the potential to be affected by the same deficient practice will be	02/04/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	155355	A. BUILDING -- B. WING	01/06/2025

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WEST BEND NURSING AND REHABILITATION	4600 W WASHINGTON AVE SOUTH BEND, IN 46619

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	from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Executive Director and Maintenance Director from 9:30 a.m. to 1:09 p.m. on 01/06/25, the facility was not able to provide documentation of a table-top exercise or a full-scale community-based exercise, a facility-based functional exercise or an actual natural or man-made emergency that required activation of the emergency plan. Based on interview at the time of record review the Maintenance Director provided a document that a Tornado drill had been completed; however, the document did not include information that facility analyzed the response or documented if the facility's emergency plan was revised as needed.		identified and what corrective action(s) will be taken; No residents were affected; 57 residents and staff have the potential to be affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Executive Director reeducated the Maintenance Director regarding the requirements to test the Emergency Preparedness Plan twice per year. Maintenance Director or designee will ensure two Emergency Preparedness Plan testing is conducted yearly, consisting of either a community-based drill, tabletop exercise or record the experience of an actual natural or man-made emergency. Executive Director will ensure that after-action analysis is included for the exercise or event. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). Executive Director or designee will present Emergency Preparedness testing exercise or actual event(s) to the QAPI Committee for additional recommendations two	

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	Based on interview at time of record review the Maintenance Director stated no other exercises were completed and no additional documentation was available. This finding was reviewed with the Executive Director and Maintenance Director at the time of the exit conference.		times per year or as indicated. 5. By what date the systemic changes for each deficiency will be completed: February 4, 2025.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/06/2025 Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420 At this Life Safety Code survey, West Bend Nursing and Rehabilitation 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 facility consists of three connected buildings: Building 01, a two story, fully sprinklered building of Type II (222) construction; Building 02, a one story, fully sprinklered building of Type V (000) construction with a partial basement and Building 03, a one story, fully sprinklered building of Type V (111) construction. The facility has a fire alarm system with smoke	K 0000	**K000** The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after 2/4/2025.	

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	155355	A. BUILDING 01 B. WING	01/06/2025

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WEST BEND NURSING AND REHABILITATION	4600 W WASHINGTON AVE SOUTH BEND, IN 46619

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	detection in the corridors, in spaces open to the corridors and battery-operated smoke detectors in all resident rooms. The building is fully protected by a 400-kW diesel power generator. The facility has a capacity of 157 beds dually certified for Medicare and Medicaid and had a census of 57 at the time of this survey. Quality Review completed on 01/08/25			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 hazardous area, an unoccupied resident room, over 50 square feet in size with combustible supplies was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect visitors, staff and residents in 1 of 8 smoke compartments on the first floor. Findings include: Based on observation and interview during tour of the facility with the Maintenance Director from 1:10 p.m. to 3:30 p.m. on 01/06/25, the corridor door to room 116 on the first floor did not self-close into the door frame. This room was being used for storage of cardboard boxes and paper goods. Based on interview at the time of observation, the Maintenance Director stated the room was being used for storage and was aware that a door closer should have been installed on the door. This finding was reviewed with the Executive Director and Maintenance Director at the time of the exit conference.	K 0321	**K321** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Maintenance Tech installed a self-closing device on the unoccupied resident room 116 door being used as storage with combustible supplies. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected. Residents, staff and visitors have the potential to be affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Tech conducted a facility audit to validate doors properly close and latch for hazardous areas and storage rooms with combustible supplies. Executive Director reeducated	02/04/2025

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	3.1-19(b)		Maintenance Director on proper door closure and latching for hazardous area and storage rooms with combustible supplies. Maintenance Director will conduct random audits to validate doors with self-closure properly latch. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool "Door Self-Closure with Secure Latch" weekly for 4 weeks, and monthly thereafter for at least 5 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: February 4, 2025.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood fire suppression system in 1 of 1 kitchen. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial	K 0324	**K324** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Executive	02/04/2025

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	Cooking Operations, Section 10.5.7 states instruction shall be provided to employees regarding the proper use of portable fire extinguishers and the manual activation of fire-extinguishing equipment. Section 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 kitchen staff. Findings include: Based on observation and interview during tour of the facility with the Maintenance Director from 1:10 p.m. to 3:30 p.m. on 01/06/25, the kitchen was provided with a UL 300 hood system. Based on interview, a kitchen staff culinary cook was asked what she would do if there was a fire underneath the hood. She replied she would use the extinguisher while pointing to the K Class fire extinguisher. She was asked a second time what would be the first thing she would do, and she replied with the same answer. She failed to indicate manually activating the Kitchen hood fire suppression system pull station. When the surveyor pointed to the pull station for the fire suppression system and asked if she knew what the device does, she replied that it activates the fire alarm and stated she did not know of any other functions. This finding was reviewed with the Executive Director and Maintenance Director at the time of the exit conference. 3.1-19(b)		Director immediately reeducated Culinary Cook on use of the hood fire suppression system and portable fire extinguishers. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected. Only kitchen staff have the potential to be affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Director or designee will educate culinary staff on the procedure to use the hood fire suppression system and portable fire extinguishers on or before 2/3/2025. Executive Director or designee will conduct random audits to validate staff understanding of procedure to use the hood fire suppression system and portable fire extinguishers. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Hood Fire	

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			Suppression System" weekly for 4 weeks, and monthly thereafter for at least 5 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: February 4, 2025.	
K 0355 SS=F Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to ensure 20 of 23 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 all residents, staff and visitors. Findings include: Based on observation and interview during tour of the facility with the Maintenance Director from 1:10 p.m. to 3:30 p.m. on 01/06/25, 20 portable fire extinguishers located throughout the facility were mounted with the top of the extinguishers between 5 feet and 6 feet above the floor. Based on interview at the time of observation, the Maintenance Director stated the fire extinguishers the extinguishers were always mounted in the same locations with the exception of one he mounted in the maintenance shop that was also mounted between 5 feet and 6 feet above the floor.	K 0355	**K355** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; The portable fire extinguisher located in the maintenance shop was lowered and reinstalled in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Executive Director educated Maintenance Director on requirements on portable fire extinguisher location in accordance with NFPA 10, Standard for Portable Fire	02/04/2025

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	This finding was reviewed with the Executive Director and Maintenance Director at the time of the exit conference. 3.1-19(b)		Extinguishers, 2010 Edition. Maintenance Director conducted an audit of all portable extinguishers to ensure proper location in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Life Safety Supervisor supports the fire extinguishers located in the fully recessed wall cabinets to remain in place; these fire extinguishers are easily accessible in an event of a fire. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Fire Extinguisher Placement” weekly for 4 weeks, and monthly thereafter for at least 5 months. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: February 4, 2025	
K 0511 SS=E	NFPA 101 Utilities - Gas and Electric			

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Bldg. 01	Based on observation and interview, the facility failed to ensure 1 of 1 ground fault circuit interrupter (GFCI) in the clean utility closet on the "Moving Forward" unit was properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could affect staff only. Findings include: Based on observation and interview during tour of the facility with the Maintenance Director from 1:10 p.m. to 3:30 p.m. on 01/06/25, when the GFCI electric receptacle in clean utility closet on the "Moving Forward" hall was tested with a GFCI tester the GFCI receptacle failed to trip and did not break the electrical circuit. When measured the receptacle was 43 inches from the center of a sink faucet. Based on interview at the time of observation, the Maintenance Director agreed the GFCI electric receptacle did not properly work when tested and the tester was indicating a "Hot/Neutral Rev" wiring issue. The Maintenance Director stated that recently an electrical contractor had installed the receptacle. This finding was reviewed with the Executive Director and Maintenance Director at the time of the exit conference. 3.1-19(b)	K 0511	**K511** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Maintenance Tech installed a new GCFI electrical receptacle in the clean utility closet on MF. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected. Only staff have the potential to be affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Executive Director validated installation of a new GCFI electrical receptable. Executive Director reeducated Maintenance Director on requirements for properly GFCI electrical receptable. Maintenance Manager/designee will conduct random audits of GCFI electrical receptacles to ensure proper functioning. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance	02/04/2025

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			Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool "GCFI" weekly for 4 weeks, and monthly thereafter for at least 5 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: February 4, 2025.	
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: 01/06/2025 Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420 At this Life Safety Code survey, West Bend Nursing and Rehabilitation 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 facility consists of three connected buildings: Building 01, a two story, fully	K 0000	**K000** The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after 2/4/2025.	

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	sprinklered building of Type II (222) construction; Building 02, a one story, fully sprinklered building of Type V (000) construction with a partial basement and Building 03, a one story, fully sprinklered building of Type V (111) construction. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery-operated smoke detectors in all resident rooms. The building is fully protected by a 400-kW diesel power generator. The facility has a capacity of 157 beds dually certified for Medicare and Medicaid and had a census of 57 at the time of this survey. Quality Review completed on 01/08/25			
K 0355 SS=F Bldg. 02	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to ensure 20 of 23 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 all residents, staff and visitors. Findings include: Based on observation and interview during tour of the facility with the Maintenance Director from 1:10 p.m. to 3:30 p.m. on 01/06/25, 20 portable fire extinguishers located throughout the facility were mounted with the top of the extinguishers between 5 feet and 6 feet above the floor. Based on interview at the time of observation, the Maintenance Director stated the fire extinguishers	K 0355	**K355** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; The portable fire extinguisher located in the maintenance shop was lowered and reinstalled in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Executive Director educated	02/04/2025

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WEST BEND NURSING AND REHABILITATION	4600 W WASHINGTON AVE SOUTH BEND, IN 46619

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	the extinguishers were always mounted in the same locations with the exception of one he mounted in the maintenance shop that was also mounted between 5 feet and 6 feet above the floor. This finding was reviewed with the Executive Director and Maintenance Director at the time of the exit conference. 3.1-19(b)		Maintenance Director on requirements on portable fire extinguisher location in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Maintenance Director conducted an audit of all portable extinguishers to ensure proper location in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Life Safety Supervisor supports the fire extinguishers located in the fully recessed wall cabinets to remain in place; these fire extinguishers are easily accessible in an event of a fire. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Fire Extinguisher Placement” weekly for 4 weeks, and monthly thereafter for at least 5 months. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155355	A. BUILDING 02 B. WING	01/06/2025

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			changes for each deficiency will be completed: February 4, 2025	
K 0000 Bldg. 03	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: 01/06/2025 Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420 At this Life Safety Code survey, West Bend Nursing and Rehabilitation 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 facility consists of three connected buildings: Building 01, a two story, fully sprinklered building of Type II (222) construction; Building 02, a one story, fully sprinklered building of Type V (000) construction with a partial basement and Building 03, a one story, fully sprinklered building of Type V (111) construction. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery-operated smoke detectors in all resident rooms. The building is fully protected by a 400-kW diesel power generator. The facility has a capacity of 157 beds dually certified for Medicare and Medicaid and had a census of 57 at	K 0000	**K000** The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after 2/4/2025.	

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	the time of this survey. Quality Review completed on 01/08/25			
K 0293 SS=E Bldg. 03	NFPA 101 Exit Signage Based on observation and interview, the facility failed to ensure 3 of 3 doors to the outside of the facility in the "Tunnel" area were not mistaken as a facility exit. LSC 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 all residents, staff and visitors in the "Tunnel" corridor. Findings include: Based on observation and interview during tour of the facility with the Maintenance Director from 1:10 p.m. to 3:30 p.m. on 01/06/25, the "Tunnel" corridor contained 3 exterior doors which could be mistaken as an exit. 2 of 3 doors lead to an enclosed courtyard with no direct access to a public way. 1 of 3 doors led to an exterior area that was fenced in and had a dense row of evergreen trees approximately 6 feet outside the door and extending approximately 20 feet to the left and right of the door. Immediately outside the door was a concrete pad approximately 4 feet by 4 feet but no means of illumination or indication to lead to a public way. Based on interview at the time of observation, the Maintenance Director stated the	K 0293	**K293** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Maintenance Director installed “no exit” signage on the three “Tunnel” corridor exit doors to provide a clear direction of no means egress. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected; 30 residents and staff have the potential to be affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Executive Director validated “no exit” signage provides clear direction of no path of egress. Executive Director/designee will educate staff on “no exit” signage placed on “Tunnel” corridor exit doors to provide clear direction of no means egress on or before 2/3/2025. Maintenance Manager/designee will conduct random audits of “no exit” signage on exit doors with no means of	02/04/2025

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	2 doors to the courtyard were not exits but 1 door could be used as an exit. This finding was reviewed with the Executive Director and Maintenance Director at the time of the exit conference. 3.1-19(b)		egress for visibility. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “No Exit Signage” weekly for 4 weeks, and monthly thereafter for at least 5 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: February 4, 2024.	
K 0355 SS=F Bldg. 03	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to ensure 20 of 23 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 all residents, staff and visitors.	K 0355	**K355** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; The portable fire extinguisher located in the maintenance shop was lowered and reinstalled in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. 2. How other residents having the	02/04/2025

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	Findings include: Based on observation and interview during tour of the facility with the Maintenance Director from 1:10 p.m. to 3:30 p.m. on 01/06/25, 20 portable fire extinguishers located throughout the facility were mounted with the top of the extinguishers between 5 feet and 6 feet above the floor. Based on interview at the time of observation, the Maintenance Director stated the fire extinguishers the extinguishers were always mounted in the same locations with the exception of one he mounted in the maintenance shop that was also mounted between 5 feet and 6 feet above the floor. This finding was reviewed with the Executive Director and Maintenance Director at the time of the exit conference. 3.1-19(b)		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Executive Director educated Maintenance Director on requirements on portable fire extinguisher location in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Maintenance Director conducted an audit of all portable extinguishers to ensure proper location in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Life Safety Supervisor supports the fire extinguishers located in the fully recessed wall cabinets to remain in place; these fire extinguishers are easily accessible in an event of a fire. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing	

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			the QAPI Audit tool “Fire Extinguisher Placement” weekly for 4 weeks, and monthly thereafter for at least 5 months. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: February 4, 2025	