STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155384	A. BUILDING -- B. WING	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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: 03/04/25 Facility Number: 000411 Provider Number: 155384 AIM Number: 100275100 At this Emergency Preparedness survey, Brickyard Healthcare-Lincoln Hills Care Center 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 86 certified beds and had a census of 61 at the time of this visit. Quality Review completed on 03/10/25 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	Preparation and submission of this Plan of Correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the facility has prepared and submits the Plan of Correction solely as a requirement under State and Federal Law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and 19 programs, and to provide the best possible care to our residents.	
E 0030 SS=C Bldg. --	403.748(c)(1), 416.54(c)(1), 418.113(c)(Names and Contact Information Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (1) Names and contact information for the following: (i) Staff (ii) Entities providing services under arrangement (iii) Residents' physicians (iv) Other LTC facilities (v) Volunteers in accordance with 42 CFR 483.73(c)(1). This deficient practice could affect all occupants.	E 0030	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The information in the EPP was updated to reflect the current contractors and contacts to include all fire protection services.	04/03/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Julie Pennington	Executive Director	03/20/2025

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

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	Findings include: Based on review of the Emergency Preparedness Plan on 03/04/25 between 9:45 p.m. and 3:15 p.m. with the Executive Director and Maintenance Director present, incorrect names and contact information for the service providers for the fire alarm system and the fire extinguishers were listed in the emergency contact numbers. The facility listed Van Guard as their service provider for their fire alarm system, however, Van Guard was purchased by another fire alarm system vendor several years ago, furthermore, the facility also listed A & B Fire Safety as their fire extinguisher vendor, which was also replaced by a different vendor during the past few years. The Maintenance Director said the facility uses a different vendor as their service for the fire alarm system and fire extinguishers. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.		How will other residents having the potential to be affected by this deficient practice be identified? The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. The information in the EPP has been updated to reflect the current contractors and contacts to include all fire protection services. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? A task has been created in TELS to check the EPP quarterly to ensure the EPP is up to date with the latest contractor and contact information. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance Director will report no less than quarterly in perpetuity the status of the EPP contacts and contractor information in the Quality Assurance Performance Improvement meeting.	
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	E 0039	What corrective action will be accomplished for those residents found to have been affected by the	04/03/2025

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	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 from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants in the facility. Findings include: Based on review of the Emergency Preparedness Plan on 03/04/25 between 9:45 a.m. and 3:15 p.m. with the Executive Director and Maintenance		deficient practice? A second emergency drill, community based, was performed on March 11, 2025. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. A second emergency drill community based, was performed on March 11, 2025. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? A task has been created in TELS to ensure that all emergency drills are conducted in a timely manner. How will the corrective action be monitored to ensure the deficient practice does not recur? The Maintenance Director will report no less than quarterly in perpetuity in the Quality Assurance Performance Improvement the status of the emergency drills.	

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	Director present, the facility was able to provide documentation of an actual event, a resident elopement on 11/29/24, however, there was no documentation of a second exercise conducted by the facility during the past 12 month period. This was confirmed by the Executive Director at the time of record review. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.			
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). 1. Based on record review and interview, the facility failed to maintain a complete and accurate written record of monthly generator load testing for 1 of 1 generator during the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires	E 0041	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? TELS has been updated with a more detailed generator task to include maintenance-free battery and replacement cycle information. All belts, hoses, load and fluid levels will be recorded as per the task. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. The TELS system has been updated with a more detailed generator task to include maintenance-free battery replacement cycle information. All belts, hoses, loads and fluid levels will be	04/03/2025

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	storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection and testing reports on 03/04/25 between 9:45 a.m. and 3:15 p.m. with the Maintenance Director present, there was monthly generator load test documentation available for the past 12 months for the emergency generator, however, the documentation was incomplete or not accurate. The "Battery Specific Gravity" line was always "NA", furthermore, the percentage of load was always documented as "100%" with no calculation included. Based on interview at the time of record review, the Maintenance Director said he has not measured the specific gravity of the generator battery, and had always put "100%" because the entire facility is powered by the emergency generator. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the		recorded as per the task. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? A new generator task list has been created in TELS to include detailed information on the maintenance-free battery and replacement cycle information. All belts, hoses, load and fluid levels will be recorded as per the task. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance Director will report no less than quarterly in perpetuity the status of the generator task list in the Quality Assurance Performance Improvement meeting.	

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	facility failed to ensure a complete written record of weekly inspections for 1 of 1 generator was maintained for 52 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection and testing reports on 03/04/25 between 9:45 a.m. and 3:15 p.m. with the Maintenance Director present, there was documentation available to show the emergency generator was inspected/tested weekly for the past 52 weeks, however, items such as, Radiator water level, oil level, belts, hoses, oil pressure, and water temperature were listed as "NA". Based on interview at the time of record review, the Maintenance Director confirmed the weekly inspection/testing documentation for the emergency generator was not complete. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.			

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K 0000 Bldg. 01	3.1-19(b) 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: 03/04/25 Facility Number: 000411 Provider Number: 155384 AIM Number: 100275100 At this Life Safety Code survey, Brickyard Healthcare-Lincoln Hills Care Center 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 with a lower level was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 86 and had a census of 61 at the time of this survey. All areas where the residents have customary access were sprinklered, except resident room closets, and all areas providing facility services were sprinklered except a metal shed containing facility storage.	K 0000	Preparation and submission of this Plan of Correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the facility has prepared and submits the Plan of Correction solely as a requirement under State and Federal Law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and 19 programs, and to provide the best possible care to our residents.	

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	Quality Review completed on 03/10/25			
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Based on observation and interview, the facility failed to ensure the lighting for 2 of 13 exit means of egress were properly maintained and would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect at least 20 residents as well as staff and visitors. Findings include: Based on observations on 03/04/25 between 3:15 p.m. and 6:30 p.m. during a tour of the facility with the Maintenance Director, there were light fixtures with two bulbs each outside the Station 2 north exit and Station 1 southwest unit exit. They were both controlled by a switch on the wall inside the door. Based on interview at the time of observation, the Maintenance Director said the lights outside the exit doors were on photo cells, but the switches could be turned off and cause the light fixtures not to work during nighttime hours. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)	K 0281	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Switch lockout guards have been installed. These guards will be affixed with tamper-proof fasteners. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. Switch lockout guards affixed with tamper-proof fasteners have been installed. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? The switch guards with tamper-proof fasteners are permanent and no further monitoring will be required. How will the correction action be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place? The Maintenance	04/03/2025

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			Director will report no less than quarterly in perpetuity the status of the switch guards in the Quality Assurance Performance Improvement meeting.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Based on observation and interview, the facility failed to ensure 1 of 1 door to the wooden deck could not be 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 3/8 inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect at least 5 residents, as well as staff and visitors. Findings include: Based on observations on 03/04/25 between 3:15 p.m. and 6:30 p.m. during a tour of the facility with the Maintenance Director, the Sun Room outside door to the wooden deck was not posted with a NO EXIT sign. Based on interview at the time of the observation, the Maintenance Director said this door was not a required exit and agreed there should be a "NO EXIT" sign on the door. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)	K 0293	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A "Not an Exit" sign has been affixed to the door to the deck. How will other residents having the potential to be affected by this deficient practice be identified? The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. A "Not an Exit" sign has been affixed to the door to the deck. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? This door sign will be monitored during the monthly TELS "Not an Exit" door check task. How will the corrective action be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place? The Maintenance Director will report no less than	04/03/2025

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			quarterly in perpetuity the status of the door exit sign in the Quality Assurance Performance Improvement meeting.	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other 1. Based on record review and interview, the facility failed to ensure the preventative maintenance for all battery operated smoke alarms in resident rooms was conducted according to manufacturer's published instructions. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents. Findings include: Based on record review on 03/04/25 between 9:45 a.m. and 3:15 p.m. with the Maintenance Director present, the "Test Battery Operated Smoke Detectors" showed monthly testing of the battery operated smoke alarms. The manufacturer's published instructions on the back side of each smoke alarm stated the alarms require weekly testing. Based on interview at the time of record review, the Maintenance Director stated the smoke alarms are tested monthly, and agreed the alarms should be tested weekly according to manufacturer's published instructions.	K 0300	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Battery powered smoke detector testing will now be performed weekly and all batteries will be changed on an annual basis per our TELS tasks. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. Battery powered smoke detector testing will now be performed weekly and all batteries will be changed on an annual basis per our TELS tasks. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Battery powered smoke detector testing will now be performed weekly and all batteries will be changed on an annual basis per the TELS tasks.	04/03/2025

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	This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure documentation for the preventative maintenance of battery operated smoke alarms in all resident rooms was complete. NFPA 72 14.2.1.1.1 states to ensure operations integrity, the system shall have an inspection, testing, and maintenance program. NFPA 72 29.10 states fire-warning equipment shall be maintained and tested in accordance with manufacturer's published instructions and per the requirements of Chapter 14. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 03/04/25 between 9:45 a.m. and 3:15 p.m. with the Maintenance Director present, the battery operated smoke alarm maintenance documentation indicate battery replacement to only 25 of the 68 battery powered smoke alarms in resident rooms during the past 12 month period. Based on interview at the time of record review, the Maintenance Director confirmed the batteries in all resident room smoke alarms have not been replaced in the past 12 month period. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		How will the corrective action be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place? The Maintenance Director will report no less than quarterly in perpetuity the status of the smoke detector testing and the changing of the batteries in the Quality Assurance Performance Improvement meeting.	

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K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings - Enclosure Based on observation and interview, the facility failed to ensure the protection of 1 of 2 stairway doors was in accordance of 19.3.1. LSC 19.3.1 requires vertical opening shall be enclosed or protected in accordance with Section 8.6. LSC 8.6.1 requires every floor that separates stories in a building shall be constructed as a smoke barrier. LSC 8.7.1.3 requires doors in barriers required to have a fire resistive rating shall have a minimum ¾ hour fire protection rating and be self-closing or automatic closing. This deficient practice could affect an unknown number of residents and staff in the lower level where the Physical Therapy gym and Beauty Shop were located. Findings include: Based on observation on 03/04/25 between 3:15 p.m. and 6:30 p.m. during a tour of the facility with the Maintenance Director, the lower level stairway door was provided with a fire rating tag, however, it was covered with paint. The paint on the fire rating tag was acknowledged by the Maintenance Director at the time of observation. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)	K 0311	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All obscured fire tags have been uncovered. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Re-education has been provided to Maintenance staff not to paint over any door tags and all door painting will be inspected to ensure this practice is not followed. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? A fire door TELS task has been added to annually inspect all fire/smoke doors, including tags. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance Director will report no less than quarterly, in perpetuity to the Quality Assurance Performance Improvement meeting the status of	04/03/2025

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	155384	A. BUILDING 01 B. WING	03/04/2025

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			the fire tags, and fire/smoke doors.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities 1. Based on observation and interview, the facility failed to ensure staff were instructed in the proper 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 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 observations on 03/04/25 between 3:15 p.m. and 6:30 p.m. during a tour of the facility with the Maintenance Director, the kitchen was provided with a UL 300 hood system. Based on interview with a cook and dishwashing kitchen staff, when asked what they would do first if there was a fire underneath the range hood and the range hood suppression system had not automatically activated, they both said they would grab the silver fire extinguisher (and pointed to it). They did not mention activating the pull station for the range hood suppression system until they were asked if they knew where it was located. This was acknowledged by the Maintenance Director at the time of observation and interview with the kitchen staff.	K 0324	What corrective action will be taken for those residents found to have been affected by the deficient practice? Fire response re-education will be given to all kitchen staff. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken. The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. Fire response re-education will be given to all kitchen staff. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? A simulated stovetop grease fire drill will be conducted in the kitchen to exercise staff knowledge post-training in March. The kitchen hood system was cleaned on 1/28/25. A TELS task was added to ensure this is completed on a semi-annual basis with the next occurrence being in July 2025. How will the corrective action be	04/03/2025

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	This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure there was documentation available to show 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect kitchen staff.		monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into practice? The Maintenance Director will report no less than quarterly and in perpetuity in the Quality Assurance Performance Improvement meeting the status of fire response understanding of the kitchen staff and the cleaning of the hood system	

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	Findings include: Based on record review on 03/04/25 between 9:45 a.m. and 3:15 p.m. with the Maintenance Director present, there were two semi-annual inspection reports available to review for the range hood exhaust system during the past 12 month period, however, they were only a month apart. They were dated 12/17/24 and 01/28/25. The previous semi-annual inspection was dated 02/15/24. Based on interview at the time of record review, the Maintenance Director confirmed there was a gap of 10 months between the previous semi-annual inspection on 02/15/24 and the 12/17/24 semi annual inspection. This finding was reviewed with the Executive Director and Maintenance Director 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 only one type of sprinkler head, i.e. quick response or standard sprinklers were installed in 2 of 12 smoke compartments. NFPA 13, 2010 Edition, Installation of Sprinkler Systems, Section 8.3.3.2 states where quick-response sprinklers are installed, all sprinklers within a compartment shall be quick-response unless otherwise permitted in Section 8.3.3.3 Section 8.3.3.4 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a compartmented space shall be changed. This deficient practice could affect at least 20 residents, staff, and visitors.	K 0351	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All mixed sprinkler heads have been replaced to ensure all heads in a smoke corridor are of the same response type. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility	04/03/2025

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	Findings include: Based on observations on 03/04/25 between 3:15 p.m. and 6:30 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. In the Station 2 corridor outside room 25 there was a quick response sprinkler head mixed with all other standard response sprinkler heads in the egress corridor. b. In the egress corridor just south of the Social Services Office and near the south exit door there was one standard response sprinkler head mixed with all other quick response sprinkler heads. Based on interview at the time of each observation, this was acknowledged by the Maintenance Director who agreed there were a mixture of different type sprinkler heads within these compartmented spaces. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		recognizes that all residents have the potential to be affected by this alleged deficient practice. All mixed sprinkler heads have been replaced to ensure all heads in a smoke corridor are of the same response type. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? A TELS task has been created for an annual inspection of the fire sprinkler system and sprinkler head type identification has been added to the task steps. How will the corrective action be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place? The Maintenance Director will report no less than quarterly and in perpetuity in the Quality Assurance Performance Improvement meeting the status of the sprinkler head placement.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on observation and interview, the facility failed to ensure sprinkler heads in 2 of 12 smoke compartments covered with corrosion were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or	K 0353	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All sprinkler heads in the shower rooms have been replaced. TELS documentation for the sprinkler control valve inspection has been	04/03/2025

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	sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect at least 4 resident, as well as staff and visitors. Findings include: Based on observations on 03/04/25 between 3:15 p.m. and 6:30 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. There was one pendent sprinkler head in the Cottage shower room covered with corrosion. b. There was one pendent sprinkler head in the Station 1 shower room covered with corrosion. Based on interview at the time of each observation, the Maintenance Director acknowledged the previously mentioned sprinkler heads were covered with corrosion. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to properly document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 dry sprinkler system during 12 of the past 12 months for the sprinkler system's control valves. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and		updated to include all steps for each occurrence. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. All sprinkler heads in the shower rooms have been replaced. TELS documentation for the sprinkler control valve inspection has been updated to include all steps for each occurrence. What measures will be put into place and what systemic chances will be made to ensure that the deficient practice does not recur? A TELS task has been created for an annual inspection of the fire sprinkler system and a step has been added to identify and replace any corroded sprinkler heads. How will the corrective action be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place? The Maintenance Director will report no less than quarterly and in perpetuity the status of the sprinkler control valve inspection and identification of corroded sprinkler heads.	

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	water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 03/04/25 between 9:45 a.m. and 3:15 p.m. with the Maintenance Director present, there was a TELS task for a monthly sprinkler system control valves inspection documentation for 12 of the past 12 months, however, the documentation of the task did not show inspection results of each monthly inspection of the dry sprinkler system control valves. Based on interview at the time of record review, the Maintenance Director said he does look at the sprinkler control valves on a weekly basis along with the sprinkler gauges, but is not able to document an inspection result with the current way TELS is designed for the facility. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)			
K 0541 SS=E Bldg. 01	NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chu			

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	Based on observation and interview, the facility failed to maintain 1 of 1 laundry chute door to be fully self-closing and positive latching. LSC 9.5.2 requires trash chutes shall be installed and maintained per NFPA 82, 2009 Edition. NFPA 82 5.2.3.3.1.1 requires all chute loading doors into a trash chute shall be provided with a self-closing, positive latching frame and gasketed door assembly. This deficient practice could affect over 20 residents, as well as staff and visitors. Findings include: Based on observations on 03/04/25 between 3:15 p.m. and 6:30 p.m. during a tour of the facility with the Maintenance Director, the Station 4 laundry chute door would not close completely and latch into its frame when tested several times. The chute door was provided with a padlock at the time of observation. Based on interview at the time of observation, the Maintenance Director said he was aware the laundry chute door was not operating as designed, and further said he has been trying to find a new latching device to fit the current door, but has had trouble locating one that will fit. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)	K 0541	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A new fire-rated access door for the laundry chute will be installed. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. A new fire-rated access door to the laundry chute will be installed and a TELS task has been created to inspect all fire rated and smoke doors. This access door has been added to the task. A separate task has been added to TELS to check this door monthly as part of ongoing inspections. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? A TELS task has been created to inspect all fire rated and smoke doors. This access door has been added to the task. A separate task has been added to TELS to check this door monthly as a part of ongoing inspections. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what	04/03/2025

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			quality assurance program will be put into place? The Maintenance Director will report no less than quarterly and in perpetuity in the Quality Assurance Performance Improvement meeting the status of the access door inspections and the laundry access door inspection.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 3 of 3 shifts during 4 of 4 quarters. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's fire drill reports on 03/04/25 between 9:45 a.m. and 3:15 p.m. with the Maintenance Director present, the facility was only able to provide nine documented fire drill reports for the past 12 month period. The following shifts and quarters were missing fire drill reports: a. The first shift (day) of the second quarter (April, May, and June) of 2024. b. The second shift (evening) of the second quarter (April, May, and June) of 2024. c. The third shift (night) of the third quarter (July, August, and September) of 2024 and fourth quarter (October, November, and December) of 2024, and first quarter (January, February, and March) of 2025. Based on interview at the time of record review, the Maintenance Director confirmed the lack of fire drill reports for the previously mentioned	K 0712	What corrective action will be accomplished for those residents found to have been affected by this deficient practice? A fire drill calendar has been created to ensure that no drills on different shifts will be missed. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. A fire drill calendar has been created to ensure that no drills on different shifts will be missed. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? A task has been added to TELS to conduct monthly fire drills once per shift within each quarter.	04/03/2025

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	shifts and quarters. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)		How will the corrective action be monitored to ensure the deficient practice will not recur, i.e, what quality assurance program will be put into place? The Maintenance Director will report no less than quarterly and in perpetuity in the Quality Assurance Performance Improvement meeting the status of the fire drills and shifts the drills were completed on.	
K 0761 SS=F Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of all fire door assemblies was completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door	K 0761	What corrective action has been taken for those residents found to have been affected by this deficient practice? The fire door assembly inspection will be completed, and documentation of a complete annual inspection will be completed. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. The fire door assembly inspection will be completed, and documentation of a complete annual inspection will be completed. What measures will be put into place and what system changes	04/03/2025

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	assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect at least 20 residents, as well as staff, and visitors. Findings include: Based on record review on 03/04/25 between 9:45 a.m. and 3:15 p.m. with the Maintenance Director present, the facility was unable to provide documentation for a complete annual inspection of all fire door assemblies for the past 12 month		will be made to ensure the deficient practice does not recur? A new task has been added in TELS to include a more detailed fire door inspection. The task will be completed annually. How will the corrective action be monitored to ensure the deficient practice does not recur, i.e, what quality assurance program will be put into place? The Maintenance Director will report no less than quarterly and in perpetuity in the Quality Assurance Performance Improvement meeting the status of the fire door inspections and documentation of the annual inspection.	

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	period. The most recent fire door assembly inspection was dated 06/04/24, however, it was not complete because it only listed the location of the fire door assembly, the date of the inspection, and a pass/fail result. No other information was documented on that report. The most recent complete fire door assembly inspection was dated 05/05/23, which included the oxygen transfilling room fire door, two stairway fire doors, and all smoke barrier doors. Based on interview at the time of record review, the Maintenance Director said there was no documentation of a complete annual inspection of all fire door assemblies available to review for the past 12 month period. Based on observations during a tour of the facility between 3:15 p.m. and 6:30 p.m., there was one oxygen transfilling room fire door assembly and two stairway fire door assemblies in the facility. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)			
K 0914 SS=E Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Based on observation, record review and interview; the facility failed to ensure complete documentation was available for all nonhospital-grade electrical receptacles in all resident room locations tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care	K 0914	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Receptacle testing has been completed, and all failed receptacles have been replaced, and the date has been documented that the receptacle was replaced. How will other residents having the potential to be affected by the	04/03/2025

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	155384	A. BUILDING 01 B. WING	03/04/2025

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	Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect at least 20 residents. Findings include: Based on record review on 03/04/25 between 9:45 a.m. and 3:15 p.m. with the Maintenance Director present, there was documentation available of an annual resident room receptacle test for non hospital-grade receptacles conducted during December of 2024. The report indicated at least 16 of the 68 resident rooms had receptacles that failed the testing and did not have a replacement date. Based on interview at the time of record review, the Maintenance Director said the electrical receptacles that failed have not yet been replaced, but have been ordered and should be arriving to the facility soon. Based on observations between 3:15 p.m. and 6:30 p.m. during a tour of the facility with the Maintenance Director, there were at least four to seven electrical receptacles in each resident room. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. Receptacle testing has been completed, and the date has been documented that the receptacle was replaced. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? A TELS task has been created to test all receptacles on an annual basis and documentation and replacement of failed receptacles. How will the corrective action be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place? The Maintenance Director will report no less than quarterly and in perpetuity in the Quality Assurance Performance Improvement meeting the status of receptacle testing and replacement of receptacles, including documentation of replacement,	
K 0918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste			

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Bldg. 01	1. Based on record review and interview, the facility failed to maintain a complete and accurate written record of monthly generator load testing for 1 of 1 generator during the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection and testing reports on 03/04/25 between 9:45 a.m. and 3:15 p.m. with the Maintenance Director present, there was monthly generator load test documentation available for the past 12 months	K 0918	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? TELS has been updated with a more detailed generator task to include maintenance-free battery and replacement cycle information. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. TELS has been updated with a more detailed generator task to include maintenance-free battery and replacement cycles information. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? TELS has been updated with a more detailed generator task to include maintenance free battery and replacement cycle information. All belts, hoses, load and fluid levels will be recorded as per the task. How will the corrective action be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place? The Maintenance	04/03/2025

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	for the emergency generator, however, the documentation was incomplete or not accurate. The "Battery Specific Gravity" line was always "NA", furthermore, the percentage of load was always documented as "100%" with no calculation included. Based on interview at the time of record review, the Maintenance Director said he has not measured the specific gravity of the generator battery, and had always put "100%" because the entire facility is powered by the emergency generator. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections for 1 of 1 generator was maintained for 52 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.		Director will report no less than quarterly and in perpetuity in the Quality Assurance Performance Improvement meeting the status of the maintenance free battery and replacement cycles information, belts, hoses, load and fluid levels for the generator.	

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	Findings include: Based on review of the generator inspection and testing reports on 03/04/25 between 9:45 a.m. and 3:15 p.m. with the Maintenance Director present, there was documentation available to show the emergency generator was inspected/tested weekly for the past 52 weeks, however, items such as, Radiator water level, oil level, belts, hoses, oil pressure, and water temperature were listed as "NA". Based on interview at the time of record review, the Maintenance Director confirmed the weekly inspection/testing documentation for the emergency generator was not complete. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)			
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review, observation, and interview; the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals,	K 0921	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? PECREE testing is underway. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. PCREE testing is underway and all patient-related electrical	04/03/2025

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	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 could affect all residents. Findings include: Based on record review on 03/04/25 between 9:45 a.m. and 3:15 p.m. with the Maintenance Director present, there was no documentation for the testing of PCREE, such as electric beds, nebulizers, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment. Based on interview at the time of record review, the Maintenance Director said the facility has not tested and documented the PCREE items and was not aware of the requirement. Based on observation between 3:15 p.m. and 6:30 p.m. during a tour of the facility with the Maintenance Director, it was revealed the facility provided PCREE such as electric beds, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment was present in the facility. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.		equipment in the facility will be tested and the findings will be documented. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? A TELS task has been added to ensure PCREE testing is completed annually. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance Director will report no less than quarterly and in perpetuity the status of the PECREE testing in the Quality Assurance Performance Improvement meeting.	

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