STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING -- B. WING	12/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ZIONSVILLE MEADOWS	675 S FORD RD ZIONSVILLE, IN 46077

(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: 12/30/24 Facility Number: 000538 Provider Number: 155620 AIM Number: 100267290 At this Emergency Preparedness survey, Zionsville Meadows was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 185 certified beds. At the time of the survey, the census was 78. Quality Review completed on 01/06/25	E 0000	Please find attached our follow up for our Emergency Preparedness Survey. May we please have paper compliance? Thank you, Dana Huffman, E.D. Zionsville Meadows	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(EP Training Program Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d)	E 0037	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Corrective action includes that new staff and new volunteers will continue to complete their Emergency Preparedness Training during orientation. Existing staff members will compete on-going education through**	01/28/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dana Huffman	E.D.	01/17/2025

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	(1). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness Program" documentation dated 04/23/24 with the Maintenance Director during record review from 9:25 a.m. to 12:40 p.m. on 12/30/24, documentation for staff training on emergency preparedness within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated he checked with the Administrator on the availability of emergency preparedness staff training documentation during the survey and stated annual staff training documentation on the emergency preparedness program conducted within the most recent twelve month period was not available for review. These findings were not reviewed with the Maintenance Director during the exit conference.		**our Relias training.** 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; **All residents have the potential to be affected. Corrective actions include ensuring that all staff complete assigned emergency training modules.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Measures put in place include the Administrator/Designee will ensure that all staff are completing emergency preparedness training in orientation and throughout the year by auditing new hire paperwork and reviewing online training modules for completion.** 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; and **Administrator/Designee will complete QAPI tool weekly x4**	

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			weeks and monthly x 6 months, then quarterly thereafter with results reported to the QAPI committee. If 100% compliance is not achieved an action plan will be developed.	
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 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	E 0039	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Corrective action includes; attempting a community based annual full scale exercise. If unable to gather community emergency resources for such facility will complete an individual, facility-based functional exercise. Facility will also document any actual natural or man-made emergency that requires activation of the emergency plan.** 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; **All residents have the potential to be affected. Corrective actions will be conducted by reaching out to local**	01/28/2025

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	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. Findings include: Based on review of "Emergency Preparedness Program" documentation dated 04/23/24 with the Maintenance Director during record review from 9:25 a.m. to 12:40 p.m. on 12/30/24, documentation for a full-scale exercise that is community-based or an individual, facility-based functional exercise within the most recent two year period was not available for review. The facility also did not document any actual natural or man-made emergency that required activation of the emergency plan within the most recent two year period. No other documentation of testing the facility's emergency plan policies was available for review at the time of the survey. Based on interview at the time of record review, the Maintenance Director stated he checked with the Administrator on the availability of emergency preparedness exercise documentation and agreed emergency preparedness testing documentation was not available for review at the time of the survey. These findings were reviewed with the Maintenance Director during the exit conference.		**emergency services to see if a full scale exercise can be planned. If unable, facility exercise will be planned. Natural or man-made emergencies will warrant our emergency plan to be activated and documentation completed.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Measures put in place include the Administrator/Designee will ensure that local emergency services are contacted in writing for proof of attempt and or confirmation of actual exercise to take place. Administrator/Designee will be in charge of planning facility based exercise and completing documentation of such if full scale option is not possible. Administrator/Designee will also be responsible to document use of emergency plan in the event of a natural or man-made emergency.** 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; and	

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			Administrator/Designee will complete QAPI tool weekly x4 weeks and monthly x 6 months, then quarterly thereafter with results reported to the QAPI committee. If 100% compliance is not achieved an action plan will be developed.	
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: 12/30/24 Facility Number: 000538 Provider Number: 155620 AIM Number: 100267290 At this Life Safety Code survey, Zionsville Meadows was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility is a split-level facility with each of the two floors exiting at ground level and was determined to be of Type II (000) construction and is fully sprinklered. The facility has a fire alarm system with smoke detection in	K 0000	Please find attached our follow up for our Emergency Preparedness Survey. May we please have paper compliance? Thank you, Dana Huffman, E.D. Zionsville Meadows	

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	the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 185 and had a census of 78 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which was not sprinklered. Quality Review completed on 01/06/25			
K 0100 SS=C Bldg. 01	NFPA 101 General Requirements - Other 1. Based on observation and interview, the facility failed to remove 1 of 3 essential electric system alarm remote annunciators which was in a location readily observed by operating personnel. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:30 p.m. on 12/30/24, one of the three remote annunciator panels located at the 200 Hall nurse's station for facility emergency generators had no electrical power and failed to illuminate its warning lights when its test button was depressed multiple times. Based on interview at the time of the observations, the Maintenance Director stated the skilled nursing facility has one diesel fuel fired emergency generator. The Maintenance Director stated the facility has an operable remote	K 0100	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **1. Corrective action includes the removal of the obsolete annunciator.** **2. Corrective action includes the removal of the defective hardware from the north door. The hardware was then restored and reinstalled and assembly lubricated for proper performance.** 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; **1.All residents have the**	01/28/2025

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	annunciator panel for the skilled nursing emergency generator and an operable remote annunciator for the assisted living emergency generator at the 200 Hall nurse's station and agreed the third annunciator panel, the old remote annunciator, at the 200 Hall nurse's station had no electrical power and should be removed. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 2 corridor door sets to the Crystal Dining Room had no impediment to closing and latching into the door frame. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Crystal Dining Room. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:30 p.m. on 12/30/24, the north door in the corridor door set to the Crystal Dining Room by Room 301 was equipped with a self closing device and latching hardware at the top of the door but the door would not latch into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Maintenance Director agreed the north door in the corridor door set to the Crystal Dining Room would not latch into the door frame when tested to close multiple times.		**potential to be affected. Audit was conducted by the Maintenance Director to ensure that no other obsolete annunciators are present.** **1 One other obsolete annunciator was located and is scheduled to be removed by vendor.** **2 All residents have the potential to be affected. Audit will be conducted by the Maintenance Director monthly to ensure that corridor doors latch correctly into the door frame.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **1 Measures put in place include monthly inspections of all public areas for any obsolete safety equipment.** **2 Measures put in place include monthly inspections of the both corridor doors to ensure that corridor doors latch correctly into the door frame.** how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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	These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		program will be put into place; and **1 Maintenance Director/Designee will complete QAPI tool monthly x 3 months. If 100% compliance is not achieved an action plan will be developed.** **2 Maintenance Director/Designee will complete QAPI tool monthly x 3 months. If 100% compliance is not achieved an action plan will be developed.**	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through 1 of 13 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:30 p.m. on 12/30/24, the exit door to the outside of the facility by Room 148 was marked as a facility exit with an exit sign. The exit door was magnetically locked and could be unlocked by	K 0222	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Corrective action includes posting the code by the keypad by the exit door to the outside of the facility by Room 148.** 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; **All residents have the potential to be affected. Audit was conducted by the Maintenance Director to ensure that all exit**	01/28/2025

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	entering a code at a keypad by the door to release the door to open. The code to release the door to open was not posted at the keypad. Based on interview at the time of the observations, the Maintenance Director agreed the code to release the door to open was not posted at the keypad. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		**doors with keypads have the codes posted at the keypad .** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Measures put in place include audit to ensure that monthly inspections of all exit doors with keypads to ensure that codes are posted by the keypads.** 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; and **Maintenance Director/Designee will complete QAPI tool weekly x 4 weeks and monthly x 3 months. If 100% compliance is not achieved an action plan will be developed.**	
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Based on observation and interview, the facility failed to ensure egress lighting for 1 of 13 exit means of egress was arranged so the failure of any single lighting fixture (bulb) 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	K 0281	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Corrective action includes vendor to complete**	01/28/2025

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	in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect over 15 residents, staff and visitors if needing to exit the facility from the 300 Hall by Room 327. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:30 p.m. on 12/30/24, the exit discharge for the 300 Hall by Room 327 was equipped with one lighting fixture with one light bulb socket for the fixture but no light bulb was in the fixture. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned exit discharge was not arranged with the minimum number of operable lighting fixtures (bulbs). These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		**work to install proper lighting at exit by room 327 on the 300 hallway.** 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; **All residents have the potential to be affected. Audit was conducted by the Maintenance Director to ensure that all exit doors have proper lighting.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Measures put in place include monthly inspections of all exit door lighting to ensure that they are functioning properly.** 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; and **Maintenance Director/Designee will complete QAPI tool monthly x 3 months. If 100% compliance is not achieved an action plan will be developed.**	

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K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 2 of over 14 hazardous areas such as trash collection rooms (exceeding 64 gallons) and fuel-fired heater rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:30 p.m. on 12/30/24, a four inch in diameter open ended conduit penetrated the ceiling of the Electrical Room by Room 307 and exposed the interstitial space above the ceiling in the room. Four 28-gallon capacity red bag waste bins and one-32 gallon capacity red bag waste bin were stored in the room. In addition, the door set to the natural gas fired boiler room near the loading dock was not equipped with positive latching devices to latch the door set into the door frame. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned two hazardous areas were not separated from other spaces by smoke resistant partitions and doors. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)	K 0321	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Corrective action includes removal of exhaust boot that was no longer in use from ceiling in the electrical room by room 307. Hole was then patched by placing a metal plate secured with tap cons.** **Corrective action includes removal of lower latch from door at the boiler room and installed at the top enabling door to latch correctly in the door frame. Also removed deadbolt lock and switched to appropriate handle. Quotes also being taken to replace entire door and door frame** 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; **All residents have the potential to be affected. Repairs were made along with decision to replace the entire door and**	01/28/2025

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			frame system which will modernize entrance to boiler room. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Measures put in place include monthly inspections of entrances to hazardous areas.** 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; and **Maintenance Director/Designee will complete QAPI tool monthly x 3 months. If 100% compliance is not achieved an action plan will be developed.**	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5 requires testing shall be performed in accordance with Table 14.4.5 Testing Frequencies.	K 0345	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Corrective action includes bids received from vendors for the replacement of failed 64 smoke detectors and**	01/28/2025

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	Section 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. Section 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. 14.4.5.3.5 states smoke detectors or smoke alarms found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Section 14.6.2.4 states a record of all inspections, testing and maintenance shall be provided that includes all applicable information requested in Figure 14.6.2.4. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Fire Alarm Supplementary Form" documentation dated 11/18/24 with the Maintenance Director during record review from 9:25 a.m. to 12:40 p.m. on 12/30/24, 64 of 126 smoke detectors failed sensitivity testing within the most recent two year period. Based on interview at the time of record review, the Maintenance Director stated the skilled nursing facility fire alarm system is not an addressable fire panel, the smoke detectors failed 11/18/24 sensitivity testing due to the contractor utilizing new sensitivity testing machinery required by the Code and agreed smoke detector repair or replace documentation on or after 11/18/24 was not available for review at the time of the survey. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		**work scheduled to replace failed smoke detectors.** 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; **All residents have the potential to be affected. Repairs to be made by vendor of 64 failed smoke detectors.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Measures put in place include sensitivity testing is conducted every 2 years by professional vendor.** 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; and **Maintenance Director/Designee will review bi-annual sensitivity testing at time of testing and address all failed detectors immediately.**	

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K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 2010 Edition, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, Section 8.6.3.4, "Minimum Distance between Sprinklers", states sprinklers shall be spaced not less than 6 feet on center. In addition, LSC 4.6.7.5 requires existing life safety features that do not meet the requirements for new buildings, but exceed the requirements for existing buildings shall not be further diminished. This deficient practice could affect over 10 residents, staff and visitors in the Crystal Dining Room. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:30 p.m. on 12/30/24, two separate wall mounted side wall sprinklers were installed, approximately, 30 inches apart in the south wall of the kitchenette area of the Crystal Dining Room. Based on interview at the time of the observations, the Maintenance Director agreed the two side wall sprinklers in the kitchenette area of the Crystal Dining Room were installed less than six feet from one another. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)	K 0351	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Corrective action includes removal of one of the sprinklers on the south wall of the kitchenette area of the Crystal Dining Room.** 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; **All residents have the potential to be affected. Repairs made to remove one of the sprinklers to ensure proper 6' on center spacing between sprinklers.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Measures put in place include visual inspection by Maintenance Director/designee to ensure that no other sprinklers are not spaced less than 6' on center.** how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be	01/28/2025

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			put into place; and **Maintenance Director/Designee will complete QAPI tool monthly x 3 months. If 100% compliance is not achieved an action plan will be developed.**	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to ensure over 15 sprinkler locations in the facility which were painted or were not in the proper orientation were replaced in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. Section 5.2.1.1.4 states any sprinkler shall be replaced that is in the improper orientation.	K 0353	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Corrective action includes sprinklers located in rooms 107, 317, outside room 122, in the electrical room by room 132, and in the closet for room 136 were all corrected to proper position. The sprinklers located in rooms 102, 103, 106, 148, 150, 153, 210, 303, and the spa by room 319 were all replaced by vendor.** 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; **All residents have the potential to be affected. Annual inspection of sprinklers in place.** what measures will be put	01/28/2025

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	This deficient practice could affect over 50 residents, staff and visitors. Findings include: Based on review of the sprinkler system inspection contractor's "Form for Inspection, Testing and Maintenance of Wet Pipe Fire Sprinkler Systems" documentation dated 04/10/24 with the Maintenance Director during record review from 9:25 a.m. to 12:40 p.m. on 12/30/24, five sprinkler locations identified as Room 107 and Room 317, outside Room 122, in the Electrical Room by Room 132 and in the closet for Room 136 were each listed in the "Deficiency Summary" section of the report due to not being in the "Proper position: upright, pendant, sidewall?" In addition, over ten sprinkler locations were listed in the "Deficiency Summary" section of the 04/10/24 inspection report because they were not "Free of foreign materials including paint". The sprinkler locations included Room 102, 103, 106, 148, 150, 153, 210, 303 and the Spa by Room 319. Based on interview at the time of record review, the Maintenance Director provided "Quote" documentation from the sprinkler system inspection contractor dated 10/28/24 for the replacement or relocation of sprinklers noted as deficient in the 04/10/24 inspection documentation. Based on interview at the time of record review, the Maintenance Director stated corrections to the deficiencies noted in the 04/10/24 inspection documentation had not yet been made by the time of the survey. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Measures put in place include visual inspection by Maintenance Director/designee to ensure that all sprinklers are in proper position and are not in disrepair.** 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; and **Maintenance Director/Designee will complete QAPI tool monthly x 3 months. If 100% compliance is not achieved an action plan will be developed.**	

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K 0355 SS=F Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to ensure 4 of 35 portable fire extinguishers were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:30 p.m. on 12/30/24, the following wall mounted ABC type portable fire extinguishers each had missing monthly inspection documentation on contractor affixed maintenance tags within the most recent twelve month period: a. in the natural gas fired boiler room near the	K 0355	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Corrective action includes 4 portable fire extinguishers were inspected and tagged properly that inspection was completed.** 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; **All residents have the potential to be affected. Location map completed by Maintenance Director to ensure that no portable fire extinguishers are missed on monthly inspections.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Measures put in place Maintenance Director will review monthly documentation to ensure no portable fire extinguishers were missed.** how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what	01/28/2025

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	service corridor for November 2024. b. in the hot water storage room near the attached loading dock for November 2024. c. in the Laundry room near the service corridor for November 2024. d. in the Maintenance Shop near the exit door to the outside of the facility for September 2024 through November 2024. The portable fire extinguisher inspection contractor had affixed a hanging tag to each fire extinguisher stating annual maintenance was performed in January 2024. Based on interview at the time of the observations, the Maintenance Director stated additional monthly fire extinguisher inspection documentation was not available for review and agreed the aforementioned portable fire extinguisher locations each had missing monthly inspection documentation within the most recent twelve month period. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		quality assurance program will be put into place; and **Maintenance Director/Designee will complete QAPI tool monthly x 3 months. If 100% compliance is not achieved an action plan will be developed.**	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Based on observation and interview, the facility failed to ensure 1 of 1 Business Office areas and 1 of 1 Moving Forward Laundry Rooms were separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto	K 0361	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Corrective action includes removal of deadbolts from both doors and replacing those lock systems with a schlage keypad handle.**	01/28/2025

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	in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect over 10 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:30 p.m. on 12/30/24, the corridor door to the Business Office area near the entrance to the 100 Hall was not equipped with a positive latching device. The corridor door to the Business Office area was equipped with a Schlage Electronics deadbolt affixed to the door which was unlocked at the time of the observations. The Business Office area had numerous offices none of which were provided with an electrically supervised automatic smoke detection system. In addition, the corridor door to the Moving Forward Laundry Room was also not provided with a positive latching device and was also not provided with an electrically supervised automatic smoke detection system. LSC 19.3.6.1(7) was not met because these areas open to the corridor were not protected by an electrically supervised automatic smoke detection system. Based on interview at the time of observation, the Maintenance Director agreed these areas open to the corridor were provided with an electrically supervised automatic smoke detection system. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		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; **All residents have the potential to be affected. Corrective actions include reviewing of all doors that are open to corridors to ensure that the correct schlage keypad handle system is in place.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Measures put in place Maintenance Director will review all doors leading to open corridors to ensure proper door hardware.** 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; and **Maintenance Director/Designee will complete QAPI tool monthly x 3 months. If 100% compliance is not achieved an action plan will be developed.**	

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K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 2 of 4 corridor doors to the kitchen had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the assisted living area by the main entrance lobby. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:30 p.m. on 12/30/24, the corridor door to the Sunshine Dining Room from the kitchen and 1 of 3 corridor doors to the kitchen from the assisted living dining room by the kitchen were propped in the fully open position with a wedge placed on the floor under the door. Both dining rooms were open to the corridor and both dining rooms were in an assisted living area which did not have a minimum 2-hour fire resistance separation from comprehensive care areas. Based on interview at the time of the observations, the Maintenance Director stated staff know they are not supposed to prop the kitchen doors open and agreed the aforementioned corridor doors had an impediment to latching into the door frame and would not resist the passage of smoke. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)	K 0363	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Corrective action includes removal of door stops/wedges from the corridor door to the Sunshine dining room from the kitchen and one of three corridor doors to the kitchen from the assisted living dining room by the kitchen.** 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; **All residents have the potential to be affected. Corrective actions include in-service education to all kitchen staff regarding not propping open any fire doors.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Measures put in place Maintenance Director/Designee to monitor fire doors in kitchen area to ensure that they remain in closed position.**	01/28/2025

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			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; and **Maintenance Director/Designee will complete QAPI tool weekly x 4 weeks and monthly x 6 months, then quarterly thereafter with results reported to the QAPI committee overseen by the executive director. If 100% compliance is not achieved an action plan will be developed.**	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 1 of 4 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the smoke barrier door set by the Business Office near the entrance to the 100 Hall. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:30 p.m. on 12/30/24, the north door in the cross corridor door set by the Business Office by the entrance to the 100 Hall failed to fully self	K 0374	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Corrective action includes vendors reviewing and quoting work to correct or replace the cross corridor door set and frame by the Business Office by the entrance to the 100 hallway.** 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; **All residents have the potential**	01/28/2025

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	close which left a large gap in between the meeting edges of the door set when tested to close multiple times. Each door in the door set was held in the fully open position with wall mounted magnetic hold open devices and was equipped with self closing devices and latching hardware to latch each door into the door frame. The bottom of the north door in the door set became stuck on the floor each time the door was manually released from the magnetic holding device. Based on interview at the time of the observations, the Maintenance Director agreed the north door in the aforementioned cross corridor door set failed to fully self close leaving a large gap in between the meeting edges of the door set. These findings were not reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		**to be affected. Corrective actions include repair or replacement of door set/frame.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Measures put in place will be to monitor proper door closure once vendor work is complete.** 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; and **Maintenance Director/Designee will complete QAPI tool monthly x 3 months. If 100% compliance is not achieved an action plan will be developed.**	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric 1. Based on observation and interview, the facility failed to ensure receptacles in 2 of over 50 resident sleeping rooms were properly grounded in accordance with NFPA 70. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition at 406.4 General Installation Requirements states receptacle outlets shall be located in branch circuits in accordance with Part	K 0511	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **1 Corrective action includes room 104 outlet was removed and neutral and hot wire connections were corrected, outlet screws**	01/28/2025

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	III of Article 210. General installation requirements shall be in accordance with 406.4(A) through (F). (A) Grounding Type. Receptacles installed on 15- and 20-ampere branch circuits shall be of the grounding type. Grounding-type receptacles shall be installed only on circuits of the voltage class and current for which they are rated, except as provided in Table 210.21(B)(2) and Table 210.21(B)(3). Exception: Nongrounding-type receptacles installed in accordance with 406.4(D). (B) To Be Grounded. Receptacles and cord connectors that have equipment grounding conductor contacts shall have those contacts connected to an equipment grounding conductor. Exception No. 1: Receptacles mounted on portable and vehicle-mounted generators in accordance with 250.34. Exception No. 2: Replacement receptacles as permitted by 406.4(D). (C) Methods of Grounding. The equipment grounding conductor contacts of receptacles and cord connectors shall be grounded by connection to the equipment grounding conductor of the circuit supplying the receptacle or cord connector. The branch-circuit wiring method shall include or provide an equipment grounding conductor to which the equipment grounding conductor contacts of the receptacle or cord connector are connected. Informational Note No. 1: See 250.118 for acceptable grounding means. Informational Note No. 2: For extensions of existing branch circuits, see 250.130. This deficient practice could affect three residents and staff. Findings include: Based on observations with the Maintenance		**torqued. Room 203 outlet was removed and loose ground connection corrected, ground screw torqued.** **2 Corrections include vendor currently quoting work to replace combustible material currently used as the encasement for the PTAC to convert to drywall.** 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; **1 All residents have the potential to be affected. Corrective actions include all outlets being inspected by the Maintenance Director.** **2 All residents have the potential to be affected. Corrective actions include all PTAC encasements to be reviewed by Maintenance Director/Designee to ensure all encasements for PTACS in all resident rooms are appropriate.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **1 Measures put in place include the Maintenance Director placing outlets on a routine inspection to ensure**	

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	Director during a tour of the facility from 1:00 p.m. to 3:30 p.m. on 12/30/24, the two electrical receptacles in the wall mounted outlet box installed at the head of the resident bed nearest the corridor door in resident sleeping Room 104 were found to have a "hot neutral" when tested with an Ideal Industries UL listed circuit tester testing device. In addition, all electrical receptacles in the two wall mounted quad outlet boxes nearest the head of the resident beds in resident sleeping Room 203 were found to have an "open ground" when tested with the Ideal Industries UL listed circuit tester testing device. Based on interview at the time of the observations, the Maintenance Director agreed the testing device showed the aforementioned electrical receptacle locations needed repair. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure electrical receptacle outlet boxes for PTACs in 1 of over 50 resident sleeping rooms was in accordance with NFPA 70. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition at 410.22 Outlet Boxes to Be Covered states in a completed installation, each outlet box shall be provided with a cover unless covered by means of a luminaire canopy, lampholder, receptacle, or similar device. Section 410.23 Covering of Combustible Material at Outlet Boxes states any combustible wall or ceiling finish exposed between the edge of a luminaire canopy or pan and an outlet box shall be covered with		**proper functioning.** **2 Measures put in place include routine inspections of all PTAC encasements in resident rooms to ensure no combustible materials are being used.** 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; and **1 Maintenance Director/Designee will complete QAPI tool monthly x 3 months. If 100% compliance is not achieved an action plan will be developed.** **2 Maintenance Director/Designee will complete QAPI tool monthly x 3 months. If 100% compliance is not achieved an action plan will be developed.**	

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	noncombustible material. This deficient practice could affect two residents and staff in resident sleeping Room 112. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:30 p.m. on 12/30/24, the electrical outlet box installed underneath the PTAC in resident sleeping Room 112 for the PTAC was covered with wood to form an encasement underneath the PTAC. Based on interview at the time of the observations, the Maintenance Director agreed the electrical outlet box was covered with combustible material. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)			
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to document activation of the fire alarm system on fire drills conducted between 6:00 a.m. and 9:00 p.m. on the second shift for 1 of 4 quarters. LSC 19.7.1.4 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility. Findings include:	K 0712	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Corrective action includes Maintenance Director now educated to understand that fire drills conducted between 6:00 a.m. and 9:00 p.m. on the second shift shall include the transmission of the fire alarm signal.** how other residents having	01/28/2025

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	Based on review of "Monthly Fire Drill Report" documentation with the Maintenance Director during record review from 9:25 a.m. to 12:40 p.m. on 12/30/24, documentation for the second shift fire drill conducted on 05/25/24 at 5:00 p.m. during the second quarter (April, May, June) 2024 indicated the drill was conducted after 6:00 a.m. but before 9:00 p.m. and did not document activation of the fire alarm system and transmission of the fire alarm signal at the time of the fire drill. The aforementioned second shift fire drill documentation stated "silent alarm" and "No" in response to "Was action taken to activate the fire alarm system?" Based on interview at the time of record review, the Maintenance Director stated the facility operates three shifts per day and company policy requires the facility to conduct a fire drill once per shift per month. The Maintenance Director provided documentation of a second shift fire drill conducted on 06/30/24 at 10:45 a.m. during the second calendar quarter of 2024 but that fire drill also did not document transmission of the fire alarm signal. Based on interview at the time of record review, the Maintenance Director stated additional second shift fire drill documentation for the second quarter 2024 was not available for review and agreed documentation for the 05/25/24 second shift fire drill conducted after 6:00 a.m. but before 9:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal at the time of the fire drill. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)		the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected. Corrective actions include ensuring the transmitting of the fire alarm signal.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Measures put in place include the Maintenance Director will review all fire drill documentation to ensure that the transmission of fire alarm signals are completed.** 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; and **Maintenance Director/Designee will complete QAPI tool monthly x 6 months. If 100% compliance is not achieved an action plan will be developed.**	

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K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of 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, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, Section 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.	K 0761	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Corrective action includes adding oxygen storage and transfilling rooms and the tenant separation wall between the comprehensive care areas and the assisted living area to the annual Doors, Locks, and Alarms inspection.** 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; **All residents have the potential to be affected. Corrective actions include ensuring that all doors are on the annual Doors, Locks, and Alarms inspection.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Measures put in place include the Maintenance Director will review all annual Doors, Locks, and Alarms inspection sheets to ensure no**	01/28/2025

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	(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 all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Fire-Smoke Doors (Opening Protectives): Annual Fire/Smoke Door Inspections" documentation dated 07/29/24 and "Doors Locks & Alarms: Test operation of doors and locks" dated 09/27/24 with the Maintenance Director during record review from 9:25 a.m. to 12:40 p.m. on 12/30/24, annual inspection documentation of fire door assemblies in the facility within the most recent twelve month period did not include all fire doors in the facility. The annual inspection documentation dated 07/29/24 did not include fire door locations at indoor oxygen storage and transfilling rooms and		**doors are absent.** 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; and **Maintenance Director/Designee will complete QAPI tool monthly x 3 months. If 100% compliance is not achieved an action plan will be developed.**	

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	at the tenant separation wall between the comprehensive care areas and the assisted living area. Based on interview at the time of record review, the Maintenance Director stated the facility has indoor oxygen storage areas and an attached assisted living area and agreed annual fire door inspection documentation for these areas within the most recent twelve month period was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:30 p.m. on 12/30/24, the corridor door to the 300 Hall oxygen storage and transfilling room had a 90-minute fire resistance rating label affixed to the hinge side of the door. Seven liquid oxygen containers and ten 'E' type oxygen cylinders were stored in the room. In addition, each door in the corridor door set serving as the entrance to the Assisted Living area near the Library by the Lounge had a 3-hour fire resistance rating label affixed to the hinge side of the door. Based on interview at the time of the observations, the Maintenance Director agreed it could not be ensured all fire door locations in the facility were included in the most recent annual fire door inspection documentation. These findings were reviewed with the 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 record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing for all resident sleeping rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012	K 0914	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Corrective action**	01/28/2025

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	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 shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care 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). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect over 20 residents, staff and visitors in the 300 Hall. Findings include: Based on review of Direct Supply TELS "Receptacle Testing" documentation dated February 2024 with the Maintenance Director during record review from 9:25 a.m. to 12:40 p.m. on 12/30/24, electrical receptacle inspection and testing documentation for all resident sleeping rooms within the most recent twelve month period was not available for review. The February 2024 documentation only included resident sleeping Rooms in the 100 and 200 Hall and did not include resident sleeping rooms in the 300 Hall. Based on interview at the time of record review, the		**includes 300 hall sleeping rooms receptacle testing has been completed and documented.** 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; **All residents have the potential to be affected. Corrective actions include ensuring that all receptacles are inspected in all resident sleeping rooms.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Measures put in place include the Maintenance Director to review all documentation for receptacle testing to ensure all resident sleeping rooms receptacles testing is completed.** 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; and **Maintenance Director/Designee will complete QAPI tool monthly x 6 months then annually. If 100%**	

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	Maintenance Director stated additional resident sleeping room electrical receptacle testing documentation was not available for review and agreed electrical receptacle inspection and testing documentation for resident sleeping rooms in the 300 Hall within the most recent twelve month period was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:30 p.m. on 12/30/24, all resident sleeping rooms in the facility, including resident sleeping rooms in the 300 Hall, had non-hospital-grade receptacles installed in the rooms. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b		**compliance is not achieved an action plan will be developed.**	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on observation and interview, the facility failed to ensure overcurrent protective devices in Emergency Power Supply Systems (EPSS) circuits were accessible only to authorized persons. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Section 6.5.4 states overcurrent devices in EPSS circuits shall be accessible to authorized persons only. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:30 p.m. on 12/30/24, one of one emergency generator transfer switches located outside the facility on the north side of the building was in an	K 0918	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Corrective action includes locking the emergency generator transfer switch storage cabinet located on the north side of the building.** 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;	01/28/2025

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	unlocked detached weatherproof storage cabinet. Based on interview at the time of the observations, the Maintenance Director stated the transfer switch was unlocked recently during contractor load bank testing for the skilled nursing emergency generator but agreed the emergency generator transfer switch was in an unlocked detached weatherproof storage cabinet outside the facility at the time of the survey. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		**All residents have the potential to be affected. Corrective actions include ensuring the storage cabinet remains locked at all times.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Measures put in place include the Maintenance Director to ensure that rounds are made to ensure that emergency generator switch storage cabinet is always locked.** 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; and **Maintenance Director will complete QAPI tool weekly x4, and monthly x 6 months then quarterly thereafter with results reported to the QAPI committee overseen by the executive director. If 100% compliance is not achieved an action plan will be developed.**	