STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155205	A. BUILDING -- B. WING	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENCROFT HEALTHCARE	1225 GREENCROFT DR GOSHEN, IN 46527

(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 Dates: 06/12/2025-06/13/2025 Facility Number: 000112 Provider Number: 155205 AIM Number: 100288710 At this Emergency Preparedness survey, Greencroft HealthCare was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 231 certified beds. At the time of the survey, the census was 146. Quality Review completed on 06/18/25	E 0000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Greencroft Goshen does not admit that the deficiencies listed on this report exist, nor does the Facility admit to any statements, findings, or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, and conclusions that form the basis for the deficiencies.	
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	E 0039	E039 – EP Testing Requirements Facility conducted a community-based full-scale exercise on 6/26/25. Documentation of the exercise is included as an attachment to this Plan of Correction. The requirements of E039 have been reviewed by the campus' Emergency Preparedness Committee to determine that all other requirements of E039 are	06/27/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brian Cook	Administrator	06/27/2025

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	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 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 record review with the Healthcare Maintenance and Maintenance Systems Administrator at 12:47 p.m. on 06/12/2025, the facility failed to provide documentation of an annual full-scale exercise that is community-based, a facility-based functional exercise when a community-based exercise is not accessible, or an actual natural or man-made emergency. Based on interview with the Healthcare Maintenance and Maintenance Systems Administrator at 12:47 p.m. on 06/12/2025, the Healthcare Maintenance stated he		being met. The Emergency Preparedness Committee has been educated on the need for a full-scale exercise every 12 months as opposed to every calendar year. Timing and dates of exercises that are required under E039 will be incorporated into the minutes of the campus' Emergency Preparedness Meeting minutes along with due dates for the next such exercise. The minutes of the Emergency Preparedness Committee will be reviewed by the facility's QAPI Committee as a double-check to ensure compliance.	

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	believed the facility had until the end of the calendar year to complete the exercise. The facility provided documentation of a facility based functional exercise that was completed in January of 2024; however, the exercise was conducted more than 12 months prior to survey. This finding was reviewed with the Administrator, Healthcare Maintenance and Maintenance Systems Administrator at the exit conference.			
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). This visit was in conjunction with the Life Safety Code Pre-Occupancy Survey that exited on 06/13/2025. Survey Dates: 06/12/2025-06/13/2025 Facility Number: 000112 Provider Number: 155205 AIM Number: 100288710 At this Life Safety Code survey, Greencroft Healthcare 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. The facility consists of the original one-story building with a partial basement determined to be	K 0000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Greencroft Goshen does not admit that the deficiencies listed on this report exist, nor does the Facility admit to any statements, findings, or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, and conclusions that form the basis for the deficiencies.	

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	of Type V (111) and the two-story 2015 addition determined to be of Type II (111). The buildings are separated by a Fire Wall with 2-Hour Fire Resistive Rating. Building #1 (the original building) is fully sprinklered, has a fire alarm system with smoke detection in the corridors, areas open to the corridor, and battery smoke alarms in all resident rooms that are not connected to the fire alarm system but provides a visual and audible signal at the nurses' station. This building is separated from independent living by a Fire Wall with 2-Hour Fire Resistive Rating. The facility has a capacity of 231 and had a census of 146 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. There is a staff-only smoking shack separate from the building that was not sprinklered. Quality Review completed on 06/18/25			
K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Based on observation, record review and interview, the facility failed to ensure documentation for the preventative maintenance of battery-operated smoke alarms in 38 resident rooms in 2 of 15 smoke compartments. 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	K 0300	K300 – Protection—Other Facility tested all 38 battery-operated smoke alarms on 6/20/25. Documentation of those tests is included in facility's Preventive Maintenance program. The 38 battery-operated smoke alarms are the only fire-warning equipment that was not compliant with K300. Maintenance staff have been trained on the manufacturer's	06/27/2025

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	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 occupants in 2 of 15 smoke compartments. Findings include: Based on record review with the Healthcare Maintenance at 10:53 a.m. on 06/12/2025, documentation of battery-operated smoke detector testing was available for review; however, documentation provided indicated smoke detectors were last tested on 05/16/2025. Based on observation with the Healthcare Maintenance 9:15 a.m. on 06/13/2025, battery-operated smoke detectors were located in 38 resident rooms in the Gables and Knoll wings of the facility. The manufacturer's label on the battery-operated smoke detectors indicated they were to be tested weekly. This finding was reviewed with the Administrator, Healthcare Maintenance and Maintenance Systems Administrator at the exit conference. 3.1-19(b)		guidance that the battery-operated some alarms should be tested weekly. Evidence of that training is included as an attachment to this Plan of Correction. Maintenance staff will supply the Administrator with a copy of the Preventive Maintenance records showing the weekly testing of the battery-operated smoke alarms every week for the next four weeks and then monthly for the next 6 months unless and until the battery-operated smoke alarms are no longer in use. Those records will then be given to the QAPI Committee for review.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 3 of 3 kitchen hood extinguishing system. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011	K 0324	K324 – Coking Facilities Devices have been obtained and installed that will ensure that the cooking appliances noted are returned to where they were when the kitchen hood extinguishing equipment was designed and installed. Pictures of the devices	06/27/2025

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	Edition Section 12.1.2.2* Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. This deficient practice could affect kitchen staff only. Findings include: Based on observation with the Healthcare Maintenance at 8:45 a.m. on 06/13/2025, cooking appliances including a gas 6-burner stove with an oven under one hood, and a gas 4-burner stove with 2 ovens and a flat-top grill was located under a second hood was located in the main kitchen. Based on observation with the Healthcare Maintenance at 9:03 a.m. on 06/13/2025, cooking appliances including a gas 2-burner stove with an oven and flat-top grill under one hood was located in the Vista wing kitchen. None of the cooking appliances were provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and/or cleaning. Based on interview with the Healthcare Maintenance at 8:45 a.m. and		is included as an attachment to this Plan of Correction. No other equipment was found to be out of compliance with K324. Maintenance and Culinary staff have been educated on the need to return cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed and the need to have positioning devices installed for any new cooking appliances going forward. Visual inspections will be made of the three cooking appliances to ensure that the devices are effective. The inspections will be documented and given to the facility Administrator weekly for four weeks and monthly for another 3 months. That documentation will be shared with the QAPI Committee at its meetings for the next 4 months.	

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	again at 9:03 a.m. on 06/13/2025, he acknowledged he had heard of the requirement and acknowledged the facility did not have an approved method to return the cooking appliances to the proper location. This finding was reviewed with the Administrator, Healthcare Maintenance and Maintenance Systems Administrator at the exit conference. 3.1-19(b)			
K 0761 SS=F Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on record review and interview, the facility failed to ensure annual inspection and testing of more than 20 fire door assemblies was were 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. LSC 8.3.3.1 states 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	K 0761	K761 – Maintenance, Inspection & Testing – Doors Facility has conducted its annual inspection and testing of its fire door assemblies. Documentation of those inspections is included as an attachment to this Plan of Correction. An audit was done to determine whether there were other fire door assemblies than the 20 noted. The additional doors were added to the Preventive Maintenance Program. Healthcare maintenance staff were trained on fire door inspections. Documentation of that training is inlcuded as an attachment to this Plan of Correction. Maintenance staff will supply the Administrator with a copy of the fire door assembly checks to ensure compliance. Those checks will then be given to the QAPI Committee for review.	06/27/2025

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	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, 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 affects all occupants. Findings include: Based on record review with the Healthcare Maintenance at 9:39 a.m. on 06/12/2025, documentation of annual fire door inspections did not include the location of the door assemblies			

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	inspected and did not indicate if all the door assemblies were inspected. Based on interview with the Healthcare Maintenance at 9:39 a.m. on 06/12/2025, he stated the documentation identified doors by a number but could not identify where each door was located. Based on interview with the Healthcare Maintenance at 9:19 a.m. on 06/13/2025, when asked if the oxygen storage room door assembly was inspected, he stated "No they weren't." This finding was reviewed with the Administrator, Healthcare Maintenance and Maintenance Systems Administrator at the exit conference. 3.1-19(b)			
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review 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, 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	K 0921	K921 – Electrical Equipment – Testing and Maintenance Facility has completed PCREE testing, including the testing of the physical integrity, resistance, leakage current, and touch current, on all equipment used in patient care rooms. The form used for the PCREE testing is included as an attachment to this Plan of Correction. An inventory was taken of all patient-care related electrical equipment, including equipment in storage and not currently in use. All items included in the inventory have been PCREE tested. Maintenance, Admissions, Social Services, and Central Supply staff have been educated on PCREE	06/27/2025

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	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 occupants. Findings include: Based on record review with the Healthcare Maintenance at 11:08 a.m. on 06/12/2025, the facility failed to provide documentation of testing of Patient Care Related Electrical Equipment (PCREE) in use in the facility as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Based on interview with the Healthcare Maintenance at 11:08 a.m. on 06/12/2025, he stated he was just informed about PCREE testing but has not performed any PCREE testing. This finding was reviewed with the Administrator, Healthcare Maintenance and Maintenance Systems Administrator at the exit conference. 3.1-19(b)		testing and the need to have patient-care related electrical equipment tested before being put into service and after any repair or modification. Audits will be conducted to determine if the equipment in those rooms has been PCREE tested. These audits will be conducted on 10 resident rooms weekly for 4 weeks and monthly for 4 months. Results of the audits will be reviewed by the facility's QAPI Committee to ensure compliance and to direct actions if concerns are noted.	
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). This visit was in conjunction with the Life Safety Code Pre-Occupancy Survey that exited on	K 0000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Greencroft Goshen does not admit that the deficiencies listed on this report exist, nor does the Facility admit	

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	06/13/2025. Survey Dates: 06/12/2025-06/13/2025 Facility Number: 000112 Provider Number: 155205 AIM Number: 100288710 At this Life Safety Code survey, Greencroft Healthcare 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. The facility consists of the original one-story building with a partial basement determined to be of Type V (111) and the two-story 2015 addition determined to be of Type II (111). The buildings are separated by a Fire Wall with 2-Hour Fire Resistive Rating. Building #2 (the two-story 2015 addition) is fully sprinklered, has a fire alarm system with smoke detection in the corridor, areas open to the corridor, and in all resident rooms. The facility has a capacity of 231 and had a census of 146 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. There is a staff only smoking shack separate from the building that was not sprinklered. Quality Review completed on 06/18/25		to any statements, findings, or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, and conclusions that form the basis for the deficiencies.	

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K 0761 SS=F Bldg. 02	NFPA 101 Maintenance, Inspection & Testing - Doors Based on record review and interview, the facility failed to ensure annual inspection and testing of more than 20 fire door assemblies was were 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. LSC 8.3.3.1 states 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, 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	K 0761	K761 – Maintenance, Inspection & Testing – Doors Facility has conducted its annual inspection and testing of its fire door assemblies. Documentation of those inspections is included as an attachment to this Plan of Correction. An audit was done to determine whether there were other fire door assemblies than the 20 noted. The additional doors were added to the Preventive Maintenance Program. Healthcare maintenance staff were trained on fire door inspections. Documentation of that training is inlcuded as an attachment to this Plan of Correction. Maintenance staff will supply the Administrator with a copy of the fire door assembly checks to ensure compliance. Those checks will then be given to the QAPI Committee for review.	06/27/2025

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	155205	A. BUILDING 02 B. WING	06/13/2025

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	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 affects all occupants. Findings include: Based on record review with the Healthcare Maintenance at 9:39 a.m. on 06/12/2025, documentation of annual fire door inspections did not include the location of the door assemblies inspected and did not indicate if all the door assemblies were inspected. Based on interview with the Healthcare Maintenance at 9:39 a.m. on 06/12/2025, he stated the documentation identified doors by a number but could not identify where each door was located. Based on interview with the Healthcare Maintenance at 9:19 a.m. on 06/13/2025, when asked if the oxygen storage room door assembly was inspected, he stated "No they weren't." This finding was reviewed with the Administrator,			

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	Healthcare Maintenance and Maintenance Systems Administrator at the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 02	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure power strips with appropriate UL listings were used in 1 of 16 resident rooms in the Cove wing and 1 of 16 resident rooms in the Haven wing. Power strips used for PCREE are required to meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) are required to meet UL 1363. This deficient practice could affect residents in 2 resident rooms. Based on observation with the Healthcare Maintenance at 1:46 p.m. on 06/12/2025, a relocatable power tap with an UL listing of E192912 was located in resident room 606 on the Cove wing. The relocatable power tap was plugged directly into a wall receptacle and supplying power to a chair, lamp, and telephone. The relocatable power tap was located on the floor behind the resident's chair. The Healthcare Maintenance removed the relocatable power tap at the time of observation. Based on interview with the Healthcare Maintenance at 1:46 p.m. on 06/12/2025, he acknowledged the relocatable power tap was not a UL 1363, 1363A or 60601-1. This finding was reviewed with the Administrator, Healthcare Maintenance and Maintenance Systems Administrator at the exit conference. 3.1-19(b)	K 0920	K920 – Electrical Equipment – Power Cords and Extens The power strips, extension cords, and relocatable power taps noted during the survey were removed. An audit was completed to determine if there were any other power strips, extension cords, and/or relocatable power taps in patient care vicinities. Those that were found were removed. Maintenance, Admissions, and Social Services staff, Unit Managers and Unit Secretaries were trained on the need to keep patient care vicinities free of power strips, extension cords, and relocatable power taps. Documentation of that training is included as an attachment to this Plan of Correction. Facility staff will complete and document a visual inspection of 10 resident rooms to determine whether the room remains free of power strips, extension cords, and relocatable power taps. This audit will be completed once/week for four weeks and then monthly for three months. The audits will be reviewed by the facility's QAPI Committee for the next four	06/27/2025

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			months.	
K 0921 SS=F Bldg. 02	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review 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, 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 occupants. Findings include: Based on record review with the Healthcare	K 0921	K921 – Electrical Equipment – Testing and Maintenance Facility has completed PCREE testing, including the testing of the physical integrity, resistance, leakage current, and touch current, on all equipment used in patient care rooms. The form used for the PCREE testing is included as an attachment to this Plan of Correction. An inventory was taken of all patient-care related electrical equipment, including equipment in storage and not currently in use. All items included in the inventory have been PCREE tested. Maintenance, Admissions, Social Services, and Central Supply staff have been educated on PCREE testing and the need to have patient-care related electrical equipment tested before being put into service and after any repair or modification. Audits will be conducted to determine if the equipment in those rooms has been PCREE tested. These audits will be conducted on 10 resident rooms weekly for 4 weeks and monthly for 4 months. Results of the audits will be reviewed by the facility's QAPI Committee to ensure	06/27/2025

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	Maintenance at 11:08 a.m. on 06/12/2025, the facility failed to provide documentation of testing of Patient Care Related Electrical Equipment (PCREE) in use in the facility as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Based on interview with the Healthcare Maintenance at 11:08 a.m. on 06/12/2025, he stated he was just informed about PCREE testing but has not performed any PCREE testing. This finding was reviewed with the Administrator, Healthcare Maintenance and Maintenance Systems Administrator at the exit conference. 3.1-19(b)		compliance and to direct actions if concerns are noted.	