STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155176	A. BUILDING -- B. WING	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLENBROOK REHABILITATION & SKILLED NURSING CENTER	3811 PARNELL AVE FORT WAYNE, IN 46805

(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: 11/12/24 Facility Number: 000092 Provider Number: 155176 AIM Number: 100266090 At this Emergency Preparedness survey, Glenbrook Rehabilitation and Skilled Nursing Center was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 82 and had a census of 59 at the time of this survey. Quality Review completed on 11/14/24	E 0000	The facility respectfully requests paper compliance	
E 0041 SS=C Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 11/12/24 at 10:00 a.m., the generator lacked monthly load testing and weekly checks required by LSC and NFPA	E 0041	The facility failed to implement the emergency power system requirements found in Health Care Facilities Code NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73 (e)(2). This deficient practice could affect all occupants. The generator lacked monthly load testing and weekly checks required by LSC and NFPA 110. POC: The Maintenance Director ensured	11/26/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jamie	Solomon	11/28/2024

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

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	110. Based on an interview at the time of record review, the Maintenance Director stated the generator was missing some of the required testing. The finding was reviewed with the Administrator, Director of Property Management, and Maintenance Director during the exit conference.		all weekly and monthly checks were current with no concerns noted. Weekly and monthly checks current as of 11/25/24. All residents could be affected. The Maintenance Director ensured all weekly and monthly checks were current. Weekly and monthly checks current as of 11/25/24. To Ensure no other residents could be affected the Maintenance Director ensured all weekly and monthly tests are current as of 11/25/24. Will do checks weekly and monthly per schedule. The Maintenance Director will conduct and document inspection of generator weekly. The Maintenance Director will perform and document monthly load testing of generator. Weekly and monthly checks current. The Administrator will review documentation to ensure all tasks are completed timely weekly x 4 weeks then monthly x 6months or until deficiency is corrected using the attached audit tool. In the event the facility Maintenance Director is an open position or not available the Administrator will contact sister facilities for assistance. Date of compliance: 11/26/24	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana	K 0000	The facility respectfully requests paper compliance	

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	Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/12/24 Facility Number: 000092 Provider Number: 155176 AIM Number: 100266090 At this Life Safety Code survey, Glenbrook Rehabilitation and Skilled Nursing Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a basement was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. Battery operated smoke detectors have been installed in the resident rooms. The facility has a capacity of 82 and had a census of 59 at the time of this survey. All areas where the residents have customary access are sprinkered. All areas providing facility services are sprinklered. Quality Review completed on 11/14/24			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Based on observation and interview, the facility failed to ensure 2 of 2 records storeroom doors were able to open from the inside if locked. LSC	K 0211	The facility failed to ensure 2 of 2 records storeroom doors were able to open from the inside if locked	11/26/2024

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	19.2.2.1 states doors complying with 7.2.1 shall be permitted. 7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied. This deficient practice could staff in the basement. Findings include: Based on observation with the Maintenance Director, Director of Property Management, and the Administrator on 11/12/22 at 12:33 p.m., the two records storeroom doors were locked with a padlock from the outside and there was no release from the inside to open the doors if locked with the padlock. This condition could trap a person inside the storerooms if locked from the outside. Based on an interview at the time of observation, the Maintenance Director agreed the storeroom doors were locked with a padlock, could not open from the inside when locked, and did remove the padlocks. The finding was reviewed with the Administrator, Director of Property Management, and Maintenance Director during the exit conference. 3.1-19(b)		LSC 19.2.2.1 states doors complying with 7.2.1 shall be permitted. 7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied. This deficient practice could affect staff in basement. 2 records storeroom doors were locked with a padlock from the outside and there was no release from the inside to open doors locked with the padlock. POC: The padlocks were immediately removed. All staff in basement could be affected, locks were removed immediately. To ensure staff in basement are not affected in future, locks were removed, and the Maintenance Director was in-serviced on appropriate locks. The Maintenance Director was in-serviced on appropriate locks for doors. The Administrator will round monthly x 6 months or until the deficiency is corrected using the tool attached to ensure all doors are arranged to be opened readily from the egress side. Date of Compliance: 11/26/24	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Based on records review, observation, and interview, the facility failed to ensure 10 of 10 battery backup lights were tested monthly.	K 0291	The facility failed to ensure 10 of 10 battery backup lights were tested monthly. Section	11/26/2024

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	Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all building occupants. Findings include: Based on an observation with the Maintenance Director, Administrator, and Director of Property Management on 11/12/24 between 11:15 a.m. and 1:00 p.m., there were 10 battery powered emergency lights throughout the building. Based on records review at 10:40 a.m., documentation for the monthly 30 second testing for the battery powered emergency lights were not documented for the months of February and September of 2024. Based on an interview at the time of record review and observations, the Maintenance Director stated not all of the required monthly testing for the emergency battery powered lights were conducted due to there not being a Maintenance Director during those times. The findings were reviewed with the Administrator, Director of Property Management, and Maintenance Director during the exit conference. 3.1-19(b)		7.9.3.1.1(1) requires functional testing to be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests for not less than 3 seconds and 5 written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all building occupants. There were 10 battery powered emergency lights throughout the building. Documentation for the monthly 30 second testing for the batter powered emergency lights were not documented for the months of February and September of 2024. POC: All battery powered lights have been tested with monthly checks current as of 11/25/24. All residents could be affected, the Maintenance Director ensured all battery powered lights have been tested. Any/all residents could be affected by deficient practice in future, the Maintenance Director ensured all battery-operated lights have been checked with no concerns. Will do checks per schedule. The Administrator will review documentation to ensure required testing of battery powered emergency lighting is completed timely monthly x 6 months or until the deficiency is corrected using the attached audit tool. In the	

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			event the facility Maintenance Director is an open position or not available the Administrator will contact sister facilities for assistance. Date of compliance: 11/26/24	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Based on observation and interview, the facility failed to ensure 1 of 2 courtyard doors to the outside of the facility were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 25 residents on the west side of the building. Findings include: Based on observation with the Maintenance Director, Director of Property Management, and the Administrator on 11/12/24 at 11:31 a.m., the west courtyard door which could be mistaken as an exit led to an enclosed courtyard. The door was not provided with a "NO EXIT" sign. Based on an interview at the time of the observation, the Maintenance Director stated the west courtyard door is not an exit to the public way and did not have a "NO EXIT" sign posted. The finding was reviewed with the Administrator, Director of Property Management, and	K 0293	The facility failed to ensure 1 of 2 courtyard doors to the outside of the facility were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the work NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the work EXIT below the word NO, unless such sign is an approved exiting sign. The deficient practice could affect 25 residents on the west side of the building. The west courtyard door which could be mistaken as an exit led to an enclosed courtyard. The door was not provided with a “NO EXIT” sign. POC: Appropriate signage was ordered with expected delivery of 11/29/24. 25 residents could be affected by the deficient practice, appropriate signs have been ordered.	11/29/2024

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	Maintenance Director during the exit conference. 3.1-19(b)		To ensure no residents are affected in the future appropriate signs have been ordered and will be placed upon delivery. The Maintenance Director will check all exit doors for appropriate signage monthly x 6 months or until the deficiency is corrected using the tool attached. The deficiency will be corrected upon arrival of new signs. Date of compliance: 11/29/24	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of 48 of 48 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents. Findings include: Based on observations with the Maintenance Director, Administrator, and Director of Property Management on 11/12/24 between 11:15 a.m. and 1:00 p.m., all residents' rooms contained battery powered smoke alarms. Based on records review	K 0300	The facility failed to ensure documentation for the preventative maintenance of 48 of 48 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Cde shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents.	11/26/2024

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	with the Maintenance Director and Administrator at 10:15 a.m., the manufacture's documentation requires weekly testing and monthly cleaning of the smoke alarms. No testing documentation for the weekly battery powered smoke alarms was documented for the months of September and August of 2024. Based on an interview at the time of record review and observations, the Maintenance Director stated not all of the required weekly testing for the battery powered smoke alarms were conducted due to there not being a Maintenance Director during those times. The findings were reviewed with the Administrator, Director of Property Management, and Maintenance Director during the exit conference. 3.1-19(b)		All residents' rooms contained battery powered smoke alarms. The manufacturer's documentation requires weekly testing and monthly cleaning of the smoke alarms. No testing documentation for the weekly battery powered smoke alarms was documented for the months of September and August 2024. POC: All battery powered smoke detectors are current with weekly testing as of 11/25/24. The deficient practice could affect all residents, the Maintenance Director ensured all battery powered smoke detectors have been checked with no concerns. To ensure no residents are affected in the future the Maintenance Director ensured all testing is current, and will perform tests per schedule. The Administrator will review documentation weekly x 4 weeks and monthly x 6 months or until the deficiency is corrected using the attached audit tool. In the event the facility Maintenance Director is an open position or not available the Administrator will contact sister facilities for assistance. All battery powered smoke detectors are current with weekly testing. Date of compliance: 11/26/24	
K 0324 SS=C Bldg. 01	NFPA 101 Cooking Facilities			

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	Based on observation, records review, and interview, the facility failed to properly install and maintain equipment protected by 1 of 1 kitchen hood extinguishing systems. LSC 9.2.3 states cooking equipment shall be in accordance with NFPA 96. NFPA 96 section 12.1.2.2 states 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, unless such installations are approved existing installations, which shall be permitted to be continued in service, and have an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. Section 10.1.2 states cooking equipment that produces grease-laden vapors and that might be a source of ignition of grease in the hood, grease removal device, or duct shall be protected by fire-extinguishing equipment. This deficient practice affects staff in the kitchen and all residents in the main dining room. The findings include: Based on records review with the Maintenance Director and Administrator on 11/12/24 at 11:10 a.m., the kitchen equipment policy indicated all cooking equipment shall be put back in the designed location by aligning the cooking equipment with the markings on the floor. Based on observation at 11:59 a.m., all cooking equipment in the main kitchen was covered by the fire suppression system, but was not provided with markings on the floor according to the facility's policy to ensure cooking appliances were returned to the approved design location after	K 0324	The facility failed to properly install and maintain equipment protected by 1 of 1 kitchen hood extinguishing systems. LSC 9.2.3 states cooking equipment shall be in accordance with NFPA 96. NFPD 96 section 12.1.2.2 states 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 extinguishing system, unless such installations are approved existing installations, which shall be permitted to be continued in service, and have an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance. And cleaning. Section 10.2.2 states cooking equipment that produces grease-laden vapors and that might be a source of ignition of grease in the hood, grease removal device, or duct shall be protected by fire-extinguishing equipment. This deficient practice affects staff in the kitchen and all residents in the main dining room. The kitchen equipment policy indicated all cooking equipment shall be put back in the designed location by aligning the cooking equipment shall be put back in the designed location by aligning the	11/26/2024

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	they had been moved for maintenance and cleaning. Based on an interview during observation and records review, the Maintenance Director and Director of Property Management stated there was a written policy for cooking equipment, but the floor did not contain markings to ensure cooking appliances were returned to an approved design location after they had been moved for maintenance and cleaning. The finding was reviewed with the Administrator, Director of Property Management, and Maintenance Director during the exit conference. 3.1-19(b)		cooking equipment with the markings on the floor. All cooking equipment in the main was covered by the fire suppression system but was not provided with the markings on the floor according to the facility's policy to ensure cooking appliances were returned to the approved design location after they had been moved for maintenance and cleaning. There is a written policy for cooking equipment, but the floor did not contain markings to ensure cooking appliances ere returned to an approved design location after they had been moved for maintenance and cleaning. POC: The Maintenance Director has marked the designed location of cooking equipment using bright colored tape. The deficient practice could affect all staff in the kitchen and all residents, the Maintenance Director has marked the designed location of the cooking equipment with bright colored tape. To ensure no staff or residents are affected in the future the Maintenance Director marked the designed location of kitchen equipment with bright colored tape and will monitor routinely to ensure placement. The Maintenance Director will monitor kitchen equipment monthly x 6 months or until the	

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			deficiency is corrected using the attached audit tool to ensure all kitchen equipment is clearly marked with design location to ensure corrected placement if moved. Please see attached pictures. Date of compliance: 11/26/24	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and the Administrator on 11/12/24 at 10:13 a.m., the following required sprinkler system inspections were not completed: a). There were no weekly inspections of the dry pipe sprinkler system's pressure gauges for the months of February, August, and September of	K 0353	The facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection. Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 5.2.4.1 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. There were no weekly inspections	11/26/2024

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	2024. b.) There were no monthly inspections of the dry pipe sprinkler system's control valves for the months of January and September of 2024 and December of 2023. During an interview at the time of record review, the Maintenance Director stated not all of the required inspections for the gauges and valves were conducted due to there not being a Maintenance Director during those times. The finding was reviewed with the Administrator, Director of Property Management, and Maintenance Director during the exit conference. 3.1-19(b)		of the dry sprinkler system's pressure gauges for the months of February, August, and September of 2024. There were no monthly inspections of the dry pipe sprinkler system's control values for the months of January and September of 2024 and December of 2023. POC: The Maintenance Director ensured all testing/inspections are current. All occupants could be affected by this deficient practice. The Maintenance Director ensured all testing/inspections are current. To ensure no occupants are affected in the future the Maintenance Director ensured all testing/inspections current, will perform test/inspections per schedule. The Administrator will review documentation to ensure weekly and monthly checks are completed weekly x 4 weeks, then monthly x 6 months or until the deficiency is corrected using the attached audit tool. In the event the Maintenance Director position is an open position or not available the Administrator will contact sister facilities for assistance. Date of compliance: 11/26/24	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility	K 0355	The facility failed to ensure 2 of 4	11/26/2024

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	155176	A. BUILDING 01 B. WING	11/12/2024

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	failed to ensure 2 of 4 portable fire extinguishers in the basement were given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could staff in the basement. Findings include: Based on observation with the Maintenance Director, Director of Property Management, and the Administrator on 11/12/24 at 12:03 p.m., the tags on two of the fire extinguishers in the basement had an annual inspection date of May 2023 while all other fire extinguishers in the basement had an inspection date of May 2024. Based on an interview during observations, the Maintenance Director stated it is most likely the two extinguishers were missed during the annual inspection. The finding was reviewed with the Administrator,		portable fire extinguishers in the basement were given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test or when specifically indicated by inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguishers that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent it's operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fir extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. The deficient practice could affect the staff in the basement. The tags on two of the fire extinguishers in the basement had an annual inspection date of May 2023 while all other fire extinguishers in the basement had	

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	Director of Property Management, and Maintenance Director during the exit conference. 3.1-19(b)		an inspection date of May 2024. POC: The Maintenance Director contacted Whitlock's for inspection. The 2 fire extinguishers were inspected by Whitlock's with tags updated on 11/21/24. The deficient practice could affect all staff in the basement, the Maintenance Director contacted Whitlock's for service/inspection. Inspection was completed on 11/21/24 To ensure no staff are affected in the future the Maintenance Director will ensure inspection with scheduled monthly tasks and report any concerns to the Administrator. The Administrator will review documentation monthly x 6 months using the attached audit tool to ensure compliance. Current deficiency corrected on 11/21/24. Please see attached documentation. Date of compliance: 11/26/24	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure penetrations through 1 of 6 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside	K 0372	The facility failed to ensure penetrations through 1 of 6 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive	11/26/2024

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	wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 30 residents in two smoke compartments. Findings include: Based on observation with the Maintenance Director, Administrator, and Director of Property Management, on 11/12/24 at 12:30 p.m., in the attic of the two-hour fire wall which was being used as a smoke barrier by room 301 had a 6-inch gap around a pipe. Based on an interview at the time of observation, the Maintenance Director agreed there was an unsealed penetration in the fire/smoke barrier by room 301. The finding was reviewed with the Administrator, Director of Property Management, and Maintenance Director during the exit conference. 3.1-19(b)		rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoked barrier, ir by use of combination there of. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through a ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 30 residents in two smoke compartments. In the attic of the two-hour fire wall which was being used as a smoke barrier by room 301 had a 6-inch gap around a pipe. POC: Fire Wall repaired using fire caulk on 11/25/24 At least 30 residents could be affected by the deficient practice, gap in fire wall was repaired using fire caulk To ensure no residents are affected in the future the Maintenance Director will inspect all fire walls monthly.	

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			The Maintenance Director will inspect all fire walls monthly x 6 months or until deficiency ensuring there are no areas that would allow penetration using the tool attached. Please see attached pictures. Date of compliance: 11/26/24	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 2 of 2 electrical outlets in the 100 hall nurses' station contained a cover plate and was protected from damage. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect 20 residents in the 10-hall. Findings include: Based on observation with the Maintenance Director, Administrator, Director of Property Management on 11/12/24 at 11:50 a.m., in the 100-hall nurses' station backroom there were two electrical outlets with missing cover plates. Based on interview at the time of observation, the Maintenance Director agreed two outlets were missing cover plates with electrical contacts visible. The finding was reviewed with the Administrator, Director of Property Management, and	K 0511	The facility failed to ensure 2 of 2 electrical outlets in the 100 hall nurses' station contained a cover plate and was protected from damage. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. The deficient practice could affect 20 residents in the 100 hall. In the 100 hall nurses' station backroom there were two electrical outlets with missing cover plates. POC: The Maintenance Director installed plate covers on the two electrical outlets in 100 hall nurses' station backroom. 20 residents could be affected by the deficient practice, the plate	11/26/2024

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	Maintenance Director during the exit conference. 3.1-19(b)		covers were installed on 2 outlets, all other outlets were inspected for broken/missing plate covers. To ensure no residents are affected in the future the Maintenance Director will inspect all outlets for broken/missing plate covers. The Maintenance Director will inspect all outlets monthly x 6 months or until deficiency is corrected using the attached tool. Please see attached documentation/pictures. Date of compliance: 11/26/24	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on observation and interview, the facility failed to ensure 2 of 2 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect staff and 10 residents in the courtyard. Findings include: Based on observation with the Maintenance Director on 11/12/24 between 9:00 a.m. and 1:00 p.m., the following cigarette butts were not properly disposed: a.) Outside the employee exit behind the dumpsters there were over 15 cigarette butts disposed on the ground inside and outside of the staff smoking area. b.) In the courtyard resident's smoking area there were over 15 cigarette butts disposed on the ground. Based on an interview at the time of observations,	K 0741	The facility failed to ensure 2 of 2 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. The deficient practice could affect staff and 10 residents in the courtyard. Outside the employee exit behind the dumpsters there were over 15 cigarette butts disposed on the ground inside and outside of the staff smoking area. In the courtyard resident's smoking area there were over 15 cigarette butts disposed on the ground. POC: Cigarette Butts were cleaned up and disposed of properly. The deficient practice could affect staff and 10 residents in the	11/26/2024

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	the Maintenance Director agreed there were cigarette butts on the ground in both smoking areas. The findings were reviewed with the Administrator, Director of Property Management, and Maintenance Director during the exit conference. 3.1-19(b)		courtyard. Cigarette butts were cleaned up and disposed of properly, all staff were in-serviced on smoking policies. To ensure no staff or residents are affected in the future all staff were in-serviced on 11/13/24, the Maintenance Director will do daily rounds and spot checks to ensure all cigarette butts are disposed of properly. The Maintenance Director will ensure appropriate receptacles are available for disposal of cigarette butts. The Administrator will audit weekly x 4 weeks then monthly times 6 months or until deficiency corrected using attached audit tool. Date of compliance: 11/26/24	
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 12 of 52 weeks and a 30-minute run under load for 3 of 12 months. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be	K 0918	The facility failed to ensure a written record of weekly inspections for the generator was maintained for 12 of the 52 weeks and a 30-minute run under load for 3 of 12 months. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110., Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply Systems (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly.	11/26/2024

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	regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on records review with the Maintenance Director and the Administrator on 11/12/24 at 10:00 a.m., The diesel generator lacked the following required testing: a.) Weekly inspections for the months of March, August, and September of 2024. b.) Monthly load testing for the months of February, March, and September of 2024. Based on an interview at the time of record review, the Maintenance Director stated some of the weekly generator inspections and monthly load testing were missed due to no Maintenance Director during the aforementioned times. . The finding was reviewed with the Administrator, Director of Property Management, and Maintenance Director during the exit conference. 3.1-19(b)		110 8.4.2 requires emergency generator sets in service to be exercised once monthly, for a minimum of 30 minutes. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff, and visitors. The diesel generator lacked weekly inspections for the months of March, August, and September of 2024, Monthly load testing for the months of February, March, and September of 2024. POC: Weekly and Monthly checks are current as of 11/25/24. The deficient practice could affect all residents, staff, and visitors. The Maintenance Director ensured all weekly and monthly checks are current with no concerns. To ensure no residents, staff, or visitors are affected in the future the Maintenance Director has ensured all weekly/monthly checks are current. Will conduct and document weekly/monthly checks per schedule. The Administrator will review documentation to ensure all tasks are completed timely weekly x 4 weeks then monthly x 6months or until deficiency is corrected using the attached audit tool. In the	

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			event the facility Maintenance Director is an open position or not available the Administrator will contact sister facilities for assistance. Date of compliance 11/26/24.	