STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155741	A. BUILDING -- B. WING	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FAIRWAY VILLAGE	2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/28/24 Facility Number: 004700 Provider Number: 155741 AIM Number: 100266630 At this Emergency Preparedness survey, Fairway Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 53 certified beds. At the time of the survey, the census was 46. Quality Review completed on 05/29/24	E 0000		
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: 05/28/24 Facility Number: 004700 Provider Number: 155741 AIM Number: 100266630 At this Life Safety Code survey, Fairway Village was found not in compliance with Requirements	K 0000	Please accept this as our honest plan pf correction for the deficiencies cited. We are respectfully requesting a desk review for this plan of correction..	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patrick Ngene	HFA	06/13/2024

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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	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 partial basement was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 53 and had a census of 46 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached storage shed. Quality Review completed on 05/29/24			
K 0321 SS=D Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of			

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	the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of over 9 hazardous areas such as boiler 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 2 staff and visitors in the basement. Findings include: Based on observations with the Maintenance Director, Field Maintenance Supervisor and Executive during a tour of the facility from 12:25 p.m. to 1:50 p.m. on 05/28/24, the corridor door to the Mechanical Room in the basement was equipped with a self-closing device and a latching mechanism to latch the door into the door frame but the door failed to fully self-close and latch into the door frame when tested to close multiple times. The Mechanical Room contained four	K 0321	What corrective actions will be accomplished for those residents found to have been affected by the deficiency practice. **The self-enclosure has been adjusted so that it can close properly on 6/12/24.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken All residents have the potential to be affected by this deficiency practice. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not	06/27/2024

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	natural gas fired water heaters. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned hazardous area was not separated from other spaces by smoke resistant partitions and doors. These findings were reviewed with the Maintenance Director, Field Maintenance Supervisor and Executive Director during the exit conference. 3.1-19(b)		reoccur. The Maintenance Director or designee will audit all doors in the facility that are equipped with self-enclosure mechanism for proper functioning by 6/27/24. **The Ed and or designee will educate the Maintenance Director by 6/27/24 on self-closing doors** How the corrective actions will be monitored to ensure the deficient practice will not recur, I e, what quality assurance program will be put into place and by what date the systemic changes for each deficiency will be completed. To ensure compliance, the executive director or designee will audit the entire facility for compliance of this deficiency. **The self-enclosure on the doors will be inspected twice a week for eight weeks, then once a week for eight weeks and monthly for two months.** **The results of the inspections will be reviewed by the idt team for compliance. If 100% is not achieved, an action plan will be developed to ensure compliance.**	
K 0351 SS=D Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required			

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	by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)			
	1. Based on record review and interview, the facility failed to ensure 2 of over 100 sprinklers were installed in accordance with NFPA 13. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition, Section 8.3.2.1 states unless the requirements of 8.3.2.2, 8.3.2.3, 8.3.2.4 or 8.3.2.5 are met, ordinary- and intermediate-temperature sprinklers shall be used throughout the buildings. This deficient practice could affect over four staff and visitors in the kitchen. Findings include: Based on review of the sprinkler system inspection contractor's "Form for Inspection, Testing and Maintenance of Dry Pipe Fire Sprinkler Systems" documentation dated 04/15/24 with the Maintenance Director, Field Maintenance Supervisor and Executive Director during record review from 8:45 a.m. to 12:25 p.m. on 05/28/24,	K 0351	What corrective actions will be accomplished for those residents found to have been affected by the deficiency practice. The sidewall sprinklers heads in the kitchen have been inspected **and replacements will be concluded by 6/27/24 to ensure regulatory compliance. Additionally, boxes were removed from the storage room to allow for the 18 inch rule to be followed and improve the spray pattern of the sprinkler heads.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken All residents, staff and visitors	06/27/2024

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	two sidewall sprinklers in the kitchen need to be replaced. The "Deficiency Summary" section of the 04/15/24 inspection report stated "(2) 1/2" vertical sidewall chrome 155 * standard response need to be changed to 1/2" vertical sidewall 200* standard response by Kitchen hood". Based on interview at the time of record review, the Executive Director provided an e-mail proposal from the contractor dated 05/28/24 at 12:05 p.m. to replace the two sprinkler heads along with the facility's e-mail response to the contractor at 12:09 p.m. to "Get it done asap". These findings were reviewed with the Maintenance Director, Field Maintenance Supervisor and Executive Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 2 of 2 storage rooms in accordance with LSC 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in Section 8.5.5.2 and Section 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect over two staff and visitors in the basement. Findings include:		have the potential to be affected by this deficiency. All sprinkler heads will be audited and any needed changes made. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not reoccur. The maintenance director or designee will audit all the sprinkler heads and ensuring proper spray patterns are followed in the facility by 6/27/24. The Executive Director and or designee will educate the maintenance Director on proper sprinkler heads and the 18 inch rule by 6/27/24 To ensure compliance, the executive director or designee will audit the entire facility for compliance of this deficiency. **The sprinkler system installation and the 18 inch clearance will be inspected twice a week for eight weeks, then once a week for eight weeks and monthly for 2 months. The results of the inspections will be reviewed by the idt team for compliance. If 100% is not achieved, an action plan will be developed to ensure compliance.**	

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	Based on observations with the Maintenance Director, Field Maintenance Supervisor and Executive during a tour of the facility from 12:25 p.m. to 1:50 p.m. on 05/28/24, the height of box storage on shelving in the Electrical Room in the basement was in a horizontal plane within ten inches below the upright pendant sprinkler deflector in the room which would obstruct the sprinkler's spray pattern. In addition, box storage on top of metal file cabinets in the adjoining storage room inside the Electrical Room was also in a horizontal plane within ten inches below the upright pendant sprinkler deflector in the room which would obstruct the sprinkler's spray pattern. Based on interview at the time of the observations, the Maintenance Director agreed the height of box storage in the rooms would obstruct the sprinkler coverage. These findings were reviewed with the Maintenance Director, Field Maintenance Supervisor and Executive Director during the exit conference. 3.1-19(b)			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test			

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	c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to ensure 5 of over 100 sprinkler heads in the facility which were painted 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. This deficient practice could affect over 20 residents, staff and visitors in the South Hall. Findings include: Based on review of the sprinkler system inspection contractor's "Form for Inspection,	K 0353	What corrective actions will be accomplished for those residents found to have been affected by the deficiency practice. **The 5 sprinklers in the south hall have been replaced as well as the 2 harsh environmental sprinklers in the semi-recessed canopy.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken **All residents, staff and visitors have the potential to be affected by this deficiency. All sprinkler heads in the facility will be inspected by the Maintenance Director or designee, and any needed changes made by 6/27/24.** What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not reoccur. **The maintenance director or designee will audit all the sprinkler heads in the facility by 6/27/24. The Ed and or designee will educate the**	06/27/2024

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	Testing and Maintenance of Dry Pipe Fire Sprinkler Systems" documentation dated 04/15/24 with the Maintenance Director, Field Maintenance Supervisor and Executive Director during record review from 8:45 a.m. to 12:25 p.m. on 05/28/24, five sprinklers installed in the South Hall were painted and need to be replaced. The "Deficiency Summary" section of the 04/15/24 inspection report stated "(5) Sidewall chrome 155 * standard response 2-piece ugly painted in South Hall" in response to the question "Free of foreign materials including paint?". Based on interview at the time of record review, the Executive Director provided an e-mail proposal from the contractor dated 05/28/24 at 12:05 p.m. to replace the five sprinkler heads along with the facility's e-mail response to the contractor at 12:09 p.m. to "Get it done asap". These findings were reviewed with the Maintenance Director, Field Maintenance Supervisor and Executive Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 5.3.1.1.2 states where sprinklers are subject to harsh environments, including corrosive atmospheres and corrosive water supplies, on a 5-year basis, either sprinklers shall be replaced, or representative sprinkler samples shall be tested. NFPA 25, Section 4.1.4.1 states the property		**Maintenance Director on appropriate sprinkler heads by 6/27/24.** How the corrective actions will be monitored to ensure the deficient practice will not recur, I e, what quality assurance program will be put into place and by what date the systemic changes for each deficiency will be completed. **The sprinkler heads will be inspected twice a week for eight weeks, then once a week for eight weeks and monthly for 2 months. The results of the inspections will be reviewed by the idt team for compliance. If 100% is not achieved, an action plan will be developed to ensure compliance.**	

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	owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect over two staff and visitors in the facility. Findings include: Based on review of the sprinkler system inspection contractor's "Form for Inspection, Testing and Maintenance of Dry Pipe Fire Sprinkler Systems" documentation dated 04/15/24 with the Maintenance Director, Field Maintenance Supervisor and Executive Director during record review from 8:45 a.m. to 12:25 p.m. on 05/28/24, two harsh environment sprinklers installed in a semi-recessed canopy need to be replaced. The "Deficiency Summary" section of the 04/15/24 inspection report stated "(2) Chrome pendant 155 * standard response semi-recessed canopy pendants are dated 2017 and need to be replaced" in response to the question "Sprinklers subject to harsh environments replaced or successfully tested in the last 5 years?". Based on interview at the time of record review, the Executive Director provided an e-mail proposal from the contractor dated 05/28/24 at 12:05 p.m. to replace the two harsh environment sprinkler heads along with the facility's e-mail response to the contractor at 12:09 p.m. to "Get it done asap". These findings were reviewed with the Maintenance Director, Field Maintenance			

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	Supervisor and Executive Director during the exit conference. 3.1-19(b)			
K 0363 SS=F Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire			

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	resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 3 of over 30 corridor doors would resist the passage of smoke. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director, Field Maintenance Supervisor and Executive during a tour of the facility from 12:25 p.m. to 1:50 p.m. on 05/28/24, a three quarter inch gap between the edge of the door and the door stop on the handle side of the door near the top of the door was noted for the corridor door to Room 101 and Room 105 when each door was in the closed and latched position. In addition, a one inch gap was noted in between the edge of the top leaf in the Dutch door and the door stop on the handle side of the door for the door to the kitchen from the main dining room when the door was in the fully closed and latched position. The corner of the door frame near the top leaf of the door was separated which caused the gap when the door was closed. The main dining room was open to the corridor. Based on interview at the time of the observations, the Maintenance Director agreed the gap in between the three corridor doors and their respective door stops would not resist the passage of smoke when fully closed and latched.	K 0363	What corrective actions will be accomplished for those residents found to have been affected by the deficiency practice. **Corridor doors have been adjusted to reduce the gaps on door 101, 105, and above Dutch doors in kitchen.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken **All residents have the potential to be affected by this deficiency. All gaps have been corrected to meet regulatory guidelines by 6/15/24.** What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not reoccur. **The Maintenance Director or designee will audit all doors in the facility by 6/27/24. This will be followed by the Administrator and or designee**	06/27/2024

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FAIRWAY VILLAGE	2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203

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	These findings were reviewed with the Maintenance Director, Field Maintenance Supervisor and Executive Director during the exit conference. 3.1-19(b)		**educating the Maintenance Director on proper gaps on doors and door frames by 6/27/24** How the corrective actions will be monitored to ensure the deficient practice will not recur, I e, what quality assurance program will be put into place and by what date the systemic changes for each deficiency will be completed. **To ensure compliance, the executive director or designee will audit the entire facility for compliance of this deficiency. The space between the doors will be inspected twice a week for eight weeks, then once a week for eight weeks and monthly for two months. The results of the inspections will be reviewed by the idt team for compliance. If 100% is not achieved, an action plan will be developed to ensure compliance.**	
K 0522 SS=F Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also:			

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	* is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 Electrical Rooms in the basement was provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for all staff in the vicinity of the room. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director, Field Maintenance Supervisor and Executive during a tour of the facility from 12:25 p.m. to 1:50 p.m. on 05/28/24, it could not be determined if the natural gas fired furnace in the Electrical Room in the basement which contained the facility's main fire alarm control panel was continually provided with combustion air supply taken directly from the outside. Based on interview at the time of the observations, the Maintenance Director agreed it could not be determined if the natural gas fired furnace in the basement Electrical Room was continually provided with combustion air supply taken directly from the outside. These findings were reviewed with the Maintenance Director, Field Maintenance Supervisor and Executive Director during the exit conference. 3.1-19(b)	K 0522	What corrective actions will be accomplished for those residents found to have been affected by the deficiency practice. **The HVAC unit has been inspected by the regional director of maintenance and has determined that an intake vent for outside will be installed in the Hvac room by 6/27/24.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken **All residents have the potential to be negatively impacted by this deficient practice.** What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not reoccur. **A new air vent will be installed in the room to provide intake combustion air from outside into the area by 6/27/24. This will provide ventilation into the electrical room and provide circulation in the electrical room and eliminate carbon monoxide from the room.**	06/27/2024

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			Education will be provided by the Administrator and or designee to the Maintenance Director on proper ventilation for gas fired appliances in closed areas by 6/27/24. How the corrective actions will be monitored to ensure the deficient practice will not recur, I e, what quality assurance program will be put into place and by what date the systemic changes for each deficiency will be completed. **To ensure compliance, the executive director or designee will audit the entire facility for compliance of this deficiency. The air vents on the electrical room will be inspected twice a week for eight weeks, then once a week for eight weeks and monthly for 2 months. The results of the inspections will be reviewed by the idt team for compliance. If 100% is not achieved, an action plan will be developed to ensure compliance.**	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is			

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	aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the third shift for 4 of 4 quarters. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS "Fire Drills" documentation with the Maintenance Director, Field Maintenance Supervisor and Executive Director during record review from 8:45 a.m. to 12:25 p.m. on 05/28/24, twelve of twelve third shift fire drills conducted within the most recent twelve month period on 06/29/23, 07/26/23, 08/15/23, 09/19/23, 10/28/23, 11/27/23, 12/22/23, 01/15/24, 02/23/24, 03/28/24, 04/15/24 and on 05/24/24 were conducted at, respectively, 4:45 a.m., 5:15 a.m., 5:40 a.m., 5:15 a.m., 5:31 a.m., 5:32 a.m., 5:20 a.m., 5:15 a.m., 5:24 a.m., 5:20 a.m., 5:23 a.m. and 4:58 a.m. Based on interview at the time of record review, the Maintenance Director stated the facility operates three shifts per day and agreed the aforementioned third shift fire drills were not conducted at unexpected times under varying conditions. These findings were reviewed with the Maintenance Director, Field Maintenance Supervisor and Executive Director during the exit conference. 3.1-19(b) and 3.1-51(c)	K 0712	What corrective actions will be accomplished for those residents found to have been affected by the deficiency practice. **A schedule has been developed to ensure that fire drills are done in line with regulatory requirements.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken **All residents, Staff and visitors have the potential to be affected by this deficiency and proper timeliness of fire drills will be established.** What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not reoccur. **The Maintenance Director or designee will conduct fire drills in the facility at different times in the facility in accordance with developed schedule and in regulatory compliance. The Ed and or designee will educate the Maintenance Director on timeliness of fire drills in accordance with regulatory standards by 6/27/24.**	06/27/2024

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			How the corrective actions will be monitored to ensure the deficient practice will not recur, I e, what quality assurance program will be put into place and by what date the systemic changes for each deficiency will be completed. **To ensure compliance, the executive director or designee will audit the fire drill times monthly for the facility. The results of the inspections will be reviewed by the idt team for compliance. If 100% is not achieved, an action plan will be developed to ensure compliance.**	