STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155496	A. BUILDING -- B. WING	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	333 W MISHAWAKA RD ELKHART, IN 46517

(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: 05/05/25 - 05/06/25 Facility Number: 000523 Provider Number: 155496 AIM Number: 100266930 At this Emergency Preparedness survey, Valley View Healthcare 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 94 certified beds. At the time of the survey, the census was 81. Quality Review completed on 05/12/25	E 0000	Preparation and execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts or alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of non-compliance cited during the survey process. Please accept this plan of correction as the provider's credible allegation of compliance. The facility is respectfully requesting a desk review	
E 0025 SS=C Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b) Arrangement with Other Facilities Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents in accordance with 42 CFR 483.73(b)(7). This deficient practice could affect all occupants. Findings include:	E 0025	="" b=""> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The administrator has reviewed the mutual aid agreement and sent for review and updated to current. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	07/09/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Olivia Shirley	Executive Director	05/25/2025

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	Based on records review and interview with the Executive Director (ED) and Maintenance Director (MD) on 05/05/25 at 12:05 p.m., development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations was available for review but the agreements were several years old, dating back to 11/22/20. Based on an interview during records review, the ED stated agreements were still in force and was unaware of the requirement to update the agreements regularly. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference on 05/06/25 with the ED, MD and Corporate Representative all present.		action(s) will be taken: All residents have the potential to be affected. These updates apply to all residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Executive Director/Maintenance Director have been educated to review facility listing identifications when reviewing Emergency Preparedness Program plan's every 12 months in QAPI. The QAPI calendar was updated for the Executive Director/Maintenance Director to review the Emergency Preparedness Program at least annually. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Annual review of the facility listing in the Emergency Preparedness Program was added to the QAPI calendar.	
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 Dates: : 05/05/25 - 05/06/25	K 0000	Preparation and execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts or alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and	

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	Facility Number: 000523 Provider Number: 155496 AIM Number: 100266930 At this Life Safety Code survey, Valley View Healthcare 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 was determined to be of Type V (111) construction and was fully sprinklered. The 500, 600, and 700 Hall Units, which are in the southern portion of the facility, are decommissioned and do not have any residents living in them, and are not separated by a firewall from the rest of the facility. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors, and 1 resident room. Battery operated smoke detectors are provided in 74 of 75 rooms resident rooms. The facility is fully protected by a 75 kW natural gas generator. The facility has a capacity of 94 beds dually certified for Medicare and Medicaid. At this survey the facility had a census of 81. All areas where residents have customary access were sprinklered. The facility has a detached garage providing storage of maintenance equipment and a shed containing storage of wheel chairs and walkers which were not sprinklered. Quality Review completed on 05/12/25		executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of non-compliance cited during the survey process. Please accept this plan of correction as the provider's credible allegation of compliance. The facility is respectfully requesting a desk review	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General			

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	Based on observation and interview, the facility failed to ensure 1 of over 9 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 24 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 05/05/25 at 3:05 p.m., the exit discharge near RR#414, marked a facility exit, had an area at the end of the sidewalk marked with lines and signage which stated "No Parking" but was obstructed with two cars where the sidewalk meets the parking lot. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference on 05/06/25 with the ED, MD and Corporate Representative all present. 3.1-19(b)	K 0211	No residents were harmed by this cited deficiency. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The signs for no parking were replaced. Staff were educated on appropriate parking spots and to not park in the fire lane. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. These updates apply to all residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance will complete rounds daily x2 weeks, three times per week for 2 weeks, and once per week for three months to ensure there is no obstruction. Any issues will be addressed immediately. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: A summary of the audits will be presented to the Quality Assurance committee monthly by ED/designee for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and	07/09/2025

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			monitoring will be done quarterly and present quarterly at the QA meeting.	
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors 1. Based on observation and interview, the facility failed to ensure the means of egress for the front exit door and courtyard gate was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect all staff, residents and visitors when needing to exit the facility. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director (MD) on 05/05/25 at 2:25 p.m., the (A) front exit door was not posted with a code in order to release the magnetic lock and exit the facility. And (B) on 05/06/25 at 11:35 a.m. the gate from the South Wing courtyard was equipped with a "green button" which is designed to release the locking mechanism. When tested, the button failed to release the magnetic hold and open the gate. The MD stated that he was aware of the issue and it would be corrected. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference on 05/06/25 with the ED, MD and Corporate Representative all present.	K 0222	/b> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The code for the front door was posted above the code box. Safe Care to repair the gate. Quote obtained. The sign for the 15 second egress was immediately placed on the affected door. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. These updates apply to all residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Department changes the magnetic lock code and will ensure that code is present on all of the keypads. The Maintenance Director will be re-educated on Exit Access Codes, lock release, and egress door signage by the Executive Director/designee. How the corrective action(s) will be	07/09/2025

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	2. Based on observation and interview, the facility failed to ensure 1 of 1 delayed egress locking arrangements in the kitchen was installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect 6 staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 05/05/25 at 3:40 p.m., the kitchen exit near the electrical room was equipped with a 15 second delayed egress. When the exit doors were tested the irreversible process to release the lock was not initiated. Based on interview at the time of observation, the Surveyor and MD tried 3 times to activate the delay egress. The MD stated the delayed egress is not working and will need to be repaired. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference on 05/06/25 with the ED, MD and		monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: An audit tool will be utilized weekly x 4 and monthly thereafter, to monitor compliance with exit codes and the gate latch. Audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	Corporate Representative all present. 3. Based on observation and interview, the facility failed to ensure the means of egress through 1 of over 5 delayed egress locks was readily accessible for all residents, staff, and visitors. LSC 7.2.1.6.1. (3) (4) states a readily visible, durable sign in letters not less than 1 in. (25mm) high and not less than 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect 15 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 05/05/25 at 3:17 p.m., the exit door located near RR#414 was provided with delayed egress magnetic locks but lacked the proper signage indicating the doors can be opened in 15 seconds by pushing on the door. Based on interview at the time of observation, the Maintenance Director acknowledged the door was equipped with delayed egress magnetic locks and lacked proper signage. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference on 05/06/25 with the ED, MD and Corporate Representative all present. 3.1-19(b)			
K 0226 SS=E Bldg. 01	NFPA 101 Horizontal Exits			

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	Based on observation and interview, the facility failed to ensure 1 of over 6 horizontal exit door sets were arranged to automatically close and latch. LSC section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. In addition NFPA 80, the Standard for Fire Doors and Other Opening Protectives, section 6.1.4.2.1 states self-closing doors shall swing easily and freely and shall be equipped with a closing device to cause the door to close and latch each time it is opened. This deficient could affect 17 residents and staff in 2 smoke compartments when occupied. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 05/06/25 at 11:03 a.m., the 1 ½ hour rated fire door set near RR#509 was in use as a horizontal exit and as a smoke barrier. When tested the doors failed to latch into the frame. Based on interview at the time of observation, the Maintenance Director stated the door set was not latching into the frame. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference on 05/06/25 with the ED, MD and Corporate Representative all present. 3.1-19(b)	K 0226	/b> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The doors were repaired to ensure proper latching and closure. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. These updates apply to all residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Department will audit all self-closing doors daily for two weeks, weekly for two weeks, and monthly for three months to ensure proper functioning. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: An audit tool will be daily for two weeks, weekly for two weeks, and monthly for three months. Audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	07/09/2025

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K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Based on observation and interview, the facility failed to ensure 1 of 9 exit discharges had a nominally level walking surface and free of obstructions. LSC 7.1.6.2 states abrupt changes in elevation of walking surfaces shall not exceed 1/4 inches. This deficient practice could affect 25 residents using the memory care exit. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 05/05/25 at 3:05 p.m., the memory care exit discharge was eroded, loose gravel, holes and braking sidewalk made the discharge uneven and presented a trip hazard. Based on interview at the time of observation, the Maintenance Director acknowledged that the walkway was in need of repair to have a complete level walking surface that was free of trip hazards leading to the public way. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference on 05/06/25 with the ED, MD and Corporate Representative all present. 3.1-19(b)	K 0271	/b> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A quote has been obtained for correction of the sidewalk for the exit discharge. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. These updates apply to all residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance and/or designee will audit exits to ensure pathways are clear and free of trip hazards daily for two weeks, weekly for two weeks, and monthly for three months Any issues will be addressed immediately. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: An audit tool will be daily for two weeks, weekly for two weeks, and monthly for three months. Audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The	07/09/2025

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			QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0281 SS=F Bldg. 01	NFPA 101 Illumination of Means of Egress Based on interview and observation, it was determined that the facility failed to provide exterior emergency lighting for all exits. LSC Section 7.9.1.1 requires emergency lighting facilities for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect all occupants in the facility including staff, visitors and residents if the facility were required to evacuate in an emergency. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 05/05/25 at 4:20 p.m., the exit discharge path leading to the public way from the (1) Dining Room Exit and (2) 200 Hall Exit to the public way was not illuminated. No lights were visible which would illuminate the paths of exit discharge. The MD was unable to locate lighting for the aforementioned exit discharge paths. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference on 05/06/25 with the ED, MD and Corporate Representative all present. 3.1-19(b)	K 0281	/b> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The signs were immediately repaired during the survey process. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. These updates apply to all residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance and/or designee will audit exits to ensure pathways are illuminated daily for two weeks, weekly for two weeks, and monthly for three months. Any issues will be addressed immediately. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: An audit tool will be daily for two weeks, weekly for two	07/09/2025

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			weeks, and monthly for three months. Audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Based on observation and interview; the facility failed to install exit signage in 1 of over 8 exits in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect up to 23 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 05/05/25 at 3:55 p.m., the dining room exit lacked directional signage once exiting the facility. The aforementioned exit discharge had 2 options when exiting (right or left). There was no directional signage present to indicate which path was the desired path to a parking lot or the public way. The non desired path would return to the building and lead to a building entrance door. The Maintenance Director agreed that the exit needed	K 0293	/b> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The signs were immediately repaired during the survey process. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. These updates apply to all residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance and/or designee will audit exits to ensure pathways are illuminated daily for two weeks, weekly for two weeks, and monthly for three months. Any issues will be addressed immediately. How the corrective action(s) will be	07/09/2025

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	to have directional signage. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference on 05/06/25 with the ED, MD and Corporate Representative all present. 3.1-19(b)		monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: An audit tool will be daily for two weeks, weekly for two weeks, and monthly for three months. Audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure the corridor doors to over 30 hazardous rooms were provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 52 residents in five smoke compartments. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 05/05/25, the corridor doors to the following hazardous areas, greater than 50 square feet, and containing combustible material, did not meet the requirements for protection of a hazardous area: a) at 3 p.m. on 05/05/25 The Boiler room on the 400 Hall did not self-close and latch. b) at 3:10 p.m. on 05/05/25 the storage closet on the 400 Hall, was larger than 50 square feet and contained combustible supplies and did not	K 0321	/b> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The identified doors have automatic closers installed and all door latches and doors replaced and/or repaired. A fire wall will be constructed between the hallway and the South Unit. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. These updates apply to all residents. What measures will be put into place or what systemic changes will be made to ensure that the	07/09/2025

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	self-close and latch. c) at 3:11 p.m. on 05/05/25 the TV room on the 400 Hall near the nurse's station did not self-close and latch. d) at 4:12 p.m. on 05/05/25 the chemical storage room door in the laundry area did not close and latch and was obstructed with a vacuum cleaner and trash can, preventing the door from closing. e) at 4:25 p.m. on 05/05/25 the storage room on the 200 Hall near the janitor's closet failed to self-close and latch. f) at 4:26 on 05/05/25 the Salon which contained lots and lots of combustible storage failed to self-close and latch. g) at 4:27 p.m. on 05/05/25 the clean linen room on the 100 Hall, equipped with a self-closing device failed to self-close and latch. h) at 4:35 p.m. on 05/05/25 the Copy Machine room contained lots and lots of combustible paper product and the door failed to self-close and latch. i) at 4:36 p.m. on 05/05/25 the Administrators Office contained lots of combustible material including 8 large boxes, the door did not self-close and latch into the door frame. j) The South Wing of the facility which had been "decommissioned," was not occupied, was not separated by a 2 hour fire wall, marked as a facility exit from the occupied area of the building -- had several rooms, including former resident rooms, most of which were being used as storage and contained lots of combustible storage product such as crates, boxes furniture and supplies. Some of the rooms had the doors removed, some had missing latching hardware which resulted in holes in the doors. Many of the rooms had the identifying numbers removed and were not easily identifiable. Some doors no longer latch and most did not have self-closing hardware. The following rooms were observed throughout the tour of the South Wing between 10:45 a.m. and 11:55 a.m. on		deficient practice does not recur: Maintenance and/or designee will audit self-closing doors weekly to ensure they are functioning appropriately. Maintenance Director and/or designee will document the audit in TELS. Any issues will be addressed immediately. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	05/06/25 with the Executive Director (ED), MD and Corporate Representative present and deemed hazardous areas with some or all of the above mentioned conditions. Rooms # 505, 507, 509, Central Supply, Case Management Office, Activities Directors Office, Unidentified room containing old covid boxes near Room # 702, 702, 704, 708, 709, 707, 705, 703, Closet near 701, Shower door, Medication Room, Janitors Closet, 601, 603, 605, 606, 604, 602, 502, Central Supply. The MD and Corporate Representative stated that a lot of work would be needed due to years of storage which had accumulated in the area. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference on 05/06/25 with the ED, MD and Corporate Representative all present. 3.1-19(b)			
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 1 of 1 kitchen hood extinguishing system. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 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	K 0324	/b> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Wheel chocks have been ordered to place on the floor for equipment positioning. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. These updates apply to all residents.	07/09/2025

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	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. The deficient practice affected 8 residents, staff, and no residents. FIndings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 05/05/25 at 3:45 p.m., the gas wheeled six (6) burner range with flat grill which was located on the cooking line under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and cleaning. Based on interview with the Maintenance Director, the facility was not aware an approved method should be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference on 05/06/25 with the ED, MD and Corporate Representative all present. 3.1-19(b)		What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance and/or designee will audit to ensure wheel chocks are correctly in place weekly x6 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: An audit tool will be used weekly x6 months. Audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0346 SS=C	NFPA 101 Fire Alarm System - Out of Service			

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Bldg. 01	Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review and interview with the Executive Director (ED) and Maintenance Director (MD) on 05/05/25 at 11:50 a.m., the fire watch plan failed to include current contact information for the facility administrator and maintenance director. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference on 05/06/25 with the ED, MD and Corporate Representative all present. 3.1-19(b)	K 0346	/b> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The contact information was updated immediately during the survey process. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. These updates apply to all residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Executive Director/Maintenance Director have been educated to review facility listing identifications when reviewing Emergency Preparedness Program plan's every 12 months in QAPI. The QAPI calendar was updated for the Executive Director/Maintenance Director to review the Emergency Preparedness Program at least annually. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Annual review of the facility listing in the Emergency Preparedness	07/09/2025

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			Program was added to the QAPI calendar.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to maintain the ceiling construction in in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff and up to 5 staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 05/06/25 at 11:00 a.m., 2 of 2 Sprinkler Heads in RR#507 were sticking down from the ceiling and were bent sideways. This resulted in missing escutcheons which did not completely cover the hole around the sprinklers. Additionally, throughout the South Wing sprinkler head issues such as described earlier were observed. The MD and Corporate Support Representative stated that they would ensure all the sprinkler heads are corrected. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference on 05/06/25 with the ED, MD and Corporate Representative all present. 3.1-19(b)	K 0351	/b> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A quote has been obtained for correction of sprinklers in the South Wing. Safe Care to correct deficiencies. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. These updates apply to all residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance and/or designee will audit exits to ensure sprinklers are appropriately positioned and annular space is appropriately covered daily for two weeks, weekly for two weeks, and monthly for three months. Any issues will be addressed immediately. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: An audit tool will be	07/09/2025

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			daily for two weeks, weekly for two weeks, and monthly for three months. Audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to maintain the ceiling construction of 3 of over 6 corridors and rooms. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice affects 24 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 05/05/25 suspended ceiling tile were missing or not installed correctly in the following locations: A) at 3:26 p.m. on 05/05/25 in the "IT" room. B) at 11:07 a.m. on 05/06/25 In the corridor near RR#702 tiles were missing. C) at 11:33 a.m. on 05/06/25 in the corridor near RR#605 tiles were missing. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit	K 0353	/b> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The tiles were fixed and/or replaced as necessary. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. These updates apply to all residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance and/or designee will audit exits to ensure tiles are in place daily for two weeks, weekly for two weeks, and monthly for three months Any issues will be addressed immediately. How the corrective action(s) will be	07/09/2025

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	conference on 05/06/25 with the ED, MD and Corporate Representative all present. 3.1-19(b)		monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: An audit tool will be daily for two weeks, weekly for two weeks, and monthly for three months. Audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the	K 0354	/b> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The contact information was updated immediately during the survey process. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. These updates apply to all residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Executive Director/Maintenance Director have been educated to	07/09/2025

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	facility. Findings include: Based on records review and interview with the Executive Director (ED) and Maintenance Director (MD) on 05/05/25 at 11:50 a.m., the fire watch plan failed to include current contact information for the facility administrator and maintenance director. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference on 05/06/25 with the ED, MD and Corporate Representative all present. 3.1-19(b)		review facility listing identifications when reviewing Emergency Preparedness Program plan's every 12 months in QAPI. The QAPI calendar was updated for the Executive Director/Maintenance Director to review the Emergency Preparedness Program at least annually. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Annual review of the facility listing in the Emergency Preparedness Program was added to the QAPI calendar.	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Based on observation and interview, the facility failed to ensure 3 of 3 alcoves with a large quantity of combustible material open to the corridor was not used as hazardous storage. LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect staff in the south wing.	K 0361	/b> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The identified items were moved to an appropriate storage location. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. These updates apply to all residents. What measures will be put into place or what systemic changes	07/09/2025

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	Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 05/06/25 at 11:05 a.m., (1) the South Wing Common Area, open to the corridor, contained hazardous storage of 12 or more bed mattresses that were flame retardant but were made from combustible material. (2) at 11:22 a.m. the Lobby Area, open to the corridor, contained at least 15 more mattresses similar to the aforementioned mattresses. (3) at 11:40 in the Second South Wing Common Area, open to the corridor, at least a dozen additional mattresses were being stored. Based on interview at the time of observation, the Maintenance Director, stated the mattresses would need to be moved. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference on 05/06/25 with the ED, MD and Corporate Representative all present. 3.1-19(b)		will be made to ensure that the deficient practice does not recur: Maintenance staff have been reeducated on the appropriate storage locations. All items have been moved to appropriate locations. Maintenance and/or designee will audit areas to ensure no items are being stored inappropriately in the identified areas daily for two weeks, weekly for two weeks, and monthly for three months Any issues will be addressed immediately. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: An audit tool will be used daily for two weeks, weekly for two weeks, and monthly for three months. Audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure all corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 staff.	K 0363	/b> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: All staff immediately reeducated on the use of items to prop open doors	07/09/2025

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	Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 05/05/25 at 2:45 p.m., the corridor door to the physicians prep room was propped open with a door stop wedge. Based on interview at the time of observation, the MD acknowledged the aforementioned corridor door would not close unless the wedge was first removed. A physician was present in the room and stated that the tiny room gets warm and that they prop the door open to get air. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference on 05/06/25 with the ED, MD and Corporate Representative all present. 3.1-19(b)		and door stop removed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. These updates apply to all residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Staff have been reeducated on not propping doors open. Maintenance and/or designee will audit areas to ensure no self closing doors are being propped open daily for two weeks, weekly for two weeks, and monthly for three months Any issues will be addressed immediately. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: An audit tool will be used daily for two weeks, weekly for two weeks, and monthly for three months. Audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0741 SS=E	NFPA 101 Smoking Regulations			

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Bldg. 01	Based on observation, records review, and interview, the facility failed to enforce 1 of 1 non-smoking policies. This deficient practice could affect residents and staff in the 200 Hall. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 05/05/25 at 4:22 p.m., vaping in the property was evident as a resident was observed vaping in resident room #208. Based on records review at 12:07 p.m., the facility's smoking policy stated "for the purpose of this policy, e-cigarettes and vaporizers will be treated as a traditional cigarette." This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference on 05/06/25 with the ED, MD and Corporate Representative all present. 3.1-19(b)	K 0741	/b> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The resident was immediately re-educated regarding the smoking policy and all smoking items removed from the room. Resident was issued a 30 day discharge notice due to non compliance with smoking policy. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. These updates apply to all residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Angel rounds are completely weekly which includes observations of smoking residents to ensure they are following the smoking policy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Angel rounds will continue to be completed weekly and ongoing to ensure compliance. Audits will be reviewed in Quality Assurance Meeting monthly for 6 months or	07/09/2025

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	155496	A. BUILDING 01 B. WING	05/06/2025

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			until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations 1. Based on observation and interview, the facility failed to ensure 1 of over 50 corridor doors contain decoration that did not exceed 30 percent of the door. LSC 18.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 18.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic	K 0753	/b> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The decorations and candles were immediately removed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. These updates apply to all residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Staff and residents were reeducated on the regulation that decorations may not exceed 30% of the door and candles not being allowed within the facility. Guardian angel rounds will be completed weekly to ensure that any decorations do not exceed the allowed amount and no candles are present. How the corrective action(s) will be monitored to ensure the deficient	07/09/2025

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	sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. This deficient practice could affect 20 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 05/05/25 at 4:29 p.m., RR#110 corridor door was covered completely with paper and Christmas decorative wrapping. The Maintenance Director agreed the corridor door was covered with a combustible decoration and stated the decoration was not treated and will be removed. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference on 05/06/25 with the ED, MD and Corporate Representative all present. 2. Based on observation and interview, the facility failed to ensure 1 of 1 South Wing Nurses Station was maintained in accordance with 19.7.5.6. LSC 19.7.5.6 prohibits combustible decorations unless an exception was met. This deficient practice could affect 5 staff. Findings include:		practice will not recur, i.e., what quality assurance program will be put into place: Audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 05/06/25 at 11:39 a.m., the nurse's station on the South Wing had a container with approximately 8 small candles. The MD and ED agreed the candles were present at the nurse's station. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference on 05/06/25 with the ED, MD and Corporate Representative all present. 3.1-19(b)			
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Based on observation and interview, the facility failed to ensure 1 of 1 storage locations of nonflammable gases equal to or greater than 3000 cubic feet were secured against unauthorized entry. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2.1 states storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. This deficient practice could affect 25 residents in the vicinity of the oxygen storage. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 05/05/25 at 3:34 p.m., the locked oxygen storage location had a key that was left in the door. The tether for the key (which was not in use) was located next to the lock making it	K 0923	/b> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The key was removed from the door and placed in an alternate location. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. These updates apply to all residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance and staff reeducated on appropriate key storage and usage. An audit tool will be used	07/09/2025

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	accessible by residents in the facility when the key was in the lock or on the tether. Based on interview at the time of the observations, the MD stated a new location for the key would need to be discussed. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference on 05/06/25 with the ED, MD and Corporate Representative all present. 3.1-19(b)		daily for two weeks, weekly for two weeks, and monthly for three months to ensure the key is in the proper place How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: An audit tool will be used daily for two weeks, weekly for two weeks, and monthly for three months to ensure the key is in the proper place. Audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer rooms was provided with a sign indicating that transferring is occurring. NFPA 99 11.5.2.3.1(3) states, the area is posted with signs indicating that trans-filling is occurring and that smoking in the immediate area is not permitted. This deficient practice could affect 25 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 05/05/25 at 3:33 p.m., the oxygen storage/transfer room did not have a posted sign making a clear distinction between when	K 0927	/b> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Signs were installed to delineate the area as a no smoking area. An in use sign was immediately installed to indicate when the room is in use or open. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be	07/09/2025

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	transferring of oxygen is occurring in this location and when it is not. Based on interview at the time of observation, the Maintenance Director stated there was not a sign stating when trans-filling oxygen is occurring and when it is not. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference on 05/06/25 with the ED, MD and Corporate Representative all present. 3.1-19(b)		affected. These updates apply to all residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance and/or designee will use an audit tool daily for two weeks, weekly for two weeks, and monthly for three months to ensure the key is in the proper place How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: An audit tool will be used daily for two weeks, weekly for two weeks, and monthly for three months to ensure the key is in the proper place. Audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	