STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155573	A. BUILDING -- B. WING	10/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF MIDDLETOWN SKILLED NURSING FACILITY, THE	981 BEECHWOOD AVE MIDDLETOWN, IN 47356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/2/23 Facility Number: 000342 Provider Number: 155573 AIM Number: 100289140 At this Emergency Preparedness survey, The Waters of Middletown Skilled Nursing Facility was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 60 certified beds. At the time of the survey, the census was 23. Quality Review completed on 10/06/23	E 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.** **Request paper compliance**	
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: 10/2/23 Facility Number: 000342 Provider Number: 155573 AIM Number: 100289140 At this Life Safety Code survey, The Waters of	K 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Roberta	Scott Shull	10/19/2023

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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	Middletown Skilled Nursing Facility 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 (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 60 and had a census of 23 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had a detached wooden storage building which was not sprinkled. Quality Review completed on 10/06/23		**with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.** **Request paper compliance**	
K 0321 SS=E 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			

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	nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of 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 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 6 staff and visitors near the kitchen. Findings include: Based on observations and interview during a tour of the facility with the Administrator and Director of Maintenance on 10/02/23 between 12:30 p.m. and 1:45 p.m., the kitchen storage room door leading into the kitchen, greater than 50 square feet contained a number of combustible items, such as, paper, plastic, and cardboard boxes. The door was equipped with a self-closing device but failed to self-close and latch into the door frame.	K 0321	**K321**– It is the intent of the facility to ensure hazardous area doors, such as storage rooms, are provided with properly working self-closing devices to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 10/2/2023 the Maintenance Supervisor/designee repaired the self-closer on the kitchen storage room door leading into the kitchen to ensure it self-closes and latches into the door frame to meet set standards. The Administrator verified the work on 10/13/2023. **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**:	10/25/2023

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	The finding was reviewed with the Director of Maintenance at the time of discovery and again during the exit conference with the Administrator and Director of Maintenance present. 3.1-19(b)		a All residents and all staff and visitors have the potential to be affected but none were. On 10/2/2023, the Maintenance Supervisor/designee inspected all hazardous area doors for self-closures and found no other negative findings. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 10/18/23 the Administrator in-service the Maintenance Supervisor and dietary staff on the requirement to ensure there are no combustible storage items beyond the 50 square feet to meet set standards. b Maintenance Supervisor/designee will inspect all hazardous areas to ensure doors to hazardous areas are equipped with a self-closure and latch into the frame as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4 MONITORING CORRECTIVE ACTION**:	

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			a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10/25/2023.**	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation, the facility failed to ensure 1 of 1 electrical junction boxes in the attic were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers	K 0511	**K511** – It is the intent of the facility to ensure electrical junction boxes in the attic are maintained in a safe and operating condition to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 10/23/23 the	10/25/2023

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	compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect staff and 15 residents. Findings include: Based on observations and interview during a tour of the facility with the Administrator and Director of Maintenance on 10/02/23 between 12:30 p.m. and 1:45 p.m., an electrical junction box in the attic space near the front entrance had exposed electrical wiring hanging out of the box. Based on interview at the time of the observation, the Director of Maintenance acknowledged the electrical junction box had 5 wires coming out of each side of the box and were held together with wire nuts. It was unclear to this surveyor and The DOM was unsure what the wires were servicing. The finding was reviewed with the Director of Maintenance at the time of discovery and again during the exit conference with the Administrator and Director of Maintenance present. 3.1-19(b)		Maintenance Supervisor/designee will secured the wires inside the electrical box including putting a cover plate on the electrical box in the attic space near the front entrance to meet set standards. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 10/18/23 the Administrator in-service the Maintenance Supervisor/designee on the requirement to secure all wires within the electrical and to ensure there is a cover on the electrical box and to not have exposed wires hanging out of the junction box to meet set standards. b The Maintenance Supervisor/designee will ensure to secure all wires within the covered electrical box and to not have exposed wires hanging out of the electrical box and will as a part of the facility's monthly Preventive Maintenance Program. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the	

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			Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10/25/2023.**	
K 0741 SS=F Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous			

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	location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on observation, records review, and interview, the facility failed enforce 1 of 1 non-smoking policies. This deficient practice could affect everyone. Findings include: Based on observations and interview during a tour of the facility with the Administrator and Director of Maintenance on 10/02/23 between 12:30 p.m. and 1:45 p.m., smoking on the property was evident due to at least 30 cigarette butts on the ground near the facility's diesel fired generator. Based on interview the Administrator stated smoking is not allowed on the facility's property, staff are allowed to smoke only in their personal vehicles per the facility's smoking policy. The finding was reviewed with the Director of	K 0741	**K741** – It is the intent of the facility to ensure to enforce nonsmoking facilities to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 10/6/2023 the Maintenance Supervisor/Housekeeping Supervisor/designee picked up the cigarette butts disposed on the ground near the facility's diesel fired generator to meet set standards. The Administrator verified the work on 10/13/2023. b On 10/20/23 the Administrator in-service all staff on the requirement that smoking is	10/25/2023

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	Maintenance at the time of discovery and again during the exit conference with the Administrator and Director of Maintenance present. 3.1-19(b)		only allowed in the designated areas and all smoking materials will be disposed of properly to meet set standards. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a Maintenance Supervisor/designee and Housekeeping Supervisor/designee will inspect the grounds of the facility to ensure cigarette butts are not present on the ground and that all employees are smoking only in the designated areas and disposing cigarettes in proper containers as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. b The Administrator will monitor adherence to the Smoking Policy. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance	

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			Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **5 This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10/25/2023.**	
K 0761 SS=F Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies	K 0761	**K761** – It is the intent of the facility to ensure annual inspection and testing of all fire door assemblies are completed in accordance with LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be protected by approved self-closing fire door assemblies to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 10/5/2023 the Maintenance Supervisor/designee conducted the annual inspection of the fire door assembly and documented the inspection results on the Annual Door Inspections log in the Life Safety Binder to meet set standards. The Administrator verified the	10/25/2023

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	shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include: Based on record review, observation and interview with the Administrator and Director of Maintenance on 10/02/23 between 9:50 a.m. and 12:30 p.m., no documentation of a current annual inspection for the fire door assemblies was available for review. The most recent		inspection and documentation on 10/16/2023. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 10/18/2023 the Administrator/Regional Property Manager in-service the Maintenance Supervisor/designee on the requirement that annual testing & inspections of fire door assemblies must be conducted and documented on the Annual Door Inspections log in the Life Safety Binder to meet set standards. b Maintenance Supervisor/designee will ensure to conduct the annual inspection of fire door assemblies and document those inspection results in the Life Safety Binder as appropriate to meet set standards. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING**	

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	documentation was dated 08/25/22. During the tour several fire doors were observed in the corridors and at the oxygen transfilling room. The finding was reviewed with the Director of Maintenance at the time of discovery and again during the exit conference with the Administrator and Director of Maintenance present. 3.1-19(b)		**CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10/25/2023.**	
K 0911 SS=E Bldg. 01	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) Based on observation and interview, the facility failed to ensure access and working space was maintained in enclosures housing electrical apparatus in 1 of 2 maintenance offices. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in	K 0911	**K911 -** It is the intent of the facility to ensure access and working space is maintained in enclosures housing electrical apparatus in maintenance offices to meet set standards.	10/25/2023

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WATERS OF MIDDLETOWN SKILLED NURSING FACILITY, THE	981 BEECHWOOD AVE MIDDLETOWN, IN 47356

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	accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2) and (3). Distances shall be measured from the live parts if such parts are exposed or from the enclosure front or opening if such are enclosed. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect over 10 residents, staff and visitors in the 300 Hall. Findings include: Based on observations and interview during a tour of the facility with the Administrator and Director of Maintenance on 10/02/23 between 12:30 p.m. and 1:45 p.m., the Mechanical room contained the facilities main Fire Alarm Control Panel along with several electrical service breaker boxes. The aforementioned utilities and FACP were surrounded with carts, boxes and debris which would make accessibility to the utility boxes very difficult. The Director of Maintenance stated he would clean up the area and maintains space around the utilities and FACP. The finding was reviewed with the Director of Maintenance at the time of discovery and again during the exit conference with the Administrator and Director of Maintenance present. 3.1-19(b)		1 **CORRECTIVE ACTIONS TAKEN**: a On 10/4/2023 the Maintenance Supervisor/designee removed the items stored in front of the main fire alarm control panel and several other electrical service breaker boxes in the Mechanical Room to meet set standards. The Administrator verified removal of the items on 10/16/2023. 2 **ALL OTHERS WITH POTENTAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. On 10/6/2023 the Maintenance Supervisor/designee inspected all other areas and found no other negative findings. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 10/18/2023 the Administrator in-service the Maintenance Supervisor/designee and all other staff on the requirement that nothing is to impede access to workspaces including fire alarm control panel and other electrical service breaker boxes to meet set standards. b Maintenance Supervisor/designee will inspect all workplaces including the fire alarm control panel and other electrical service breaker boxes to ensure nothing is impeding access to the workspaces as a part of the facility's monthly	

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	155573	A. BUILDING 01 B. WING	10/02/2023

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			Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10/25/2023.**	

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K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing at all resident rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1	K 0914	**K914**– It is the intent of the facility to ensure documentation of electrical outlet receptacle testing for all resident rooms is available for review in accordance with NFPA 99 to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On 10/23/2023 the Maintenance Supervisor/designee completed the annual inspection of the electrical receptacles	10/25/2023

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	states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all residents. Findings include: Based on record review and interview with the Administrator and Director of Maintenance on 10/02/23 between 9:50 a.m. and 12:30 p.m., an itemized listing of inspection and testing electrical outlet receptacles in resident rooms for the most recent twelve-month period was not available for review. The most recent documentation provided for review showed the testing was completed over a three-day period dated March 7, 8 and 9 of 2022. The Director of Maintenance stated he had not gotten around to doing the receptacle testing this year. The finding was reviewed with the Director of Maintenance at the time of discovery and again during the exit conference with the Administrator and Director of Maintenance present. 3.1-19(b)		installed in resident sleeping rooms throughout the building and documented the results on the Annual Receptacle Testing Log in the Life Safety Binder to meet set standards. The Administrator verified the inspections were complete and plan was documented to replace on 10/16/2023. **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 10/18/2023 the Administrator in-service the Maintenance Supervisor/designee on the requirement that electrical receptacles in resident sleeping rooms must be tested annually and documented on the Annual Receptacle Testing Log in the Life Safety Binder to meet set standards. b Maintenance Supervisor/designee will ensure to properly test electrical receptacles installed in resident sleeping rooms throughout the building annually as part of the facility's Preventive Maintenance Program and document those inspection results on the Annual Receptacle Testing Log as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance	

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			Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator annually and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10/25/2023.**	