STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155678	A. BUILDING -- B. WING	03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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: 03/17/25 Facility Number: 002667 Provider Number: 155678 AIM Number: 200300090 At this Emergency Preparedness survey, Waterford Place Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 103 and had a census of 73 at the time of this survey. Quality Review completed on 03/20/25	E 0000	The submission of this plan of correction does not indicate an admission by Waterford Place Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Waterford Place of Kokomo. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests desk review for substantial 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: 03/17/25 Facility Number: 002667 Provider Number: 155678 AIM Number: 200300090	K 0000	The submission of this plan of correction does not indicate an admission by Waterford Place Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Waterford Place of Kokomo. The facility recognizes its obligation to provide legally and	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Justin Rife	Area Executive Director	04/04/2025

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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	At this Life Safety Code survey, Waterford Place Health Campus 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 facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and in the resident sleeping rooms. The facility has a capacity of 103 and had a census of 73 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 03/20/25		medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests desk review for substantial compliance.	
K 0161 SS=E Bldg. 01	NFPA 101 Building Construction Type and Height Based on record review, observation and interview; the facility failed to maintain the building construction type for a facility with Type V(111) construction. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Main Dining Room. Findings include: Based on review of facility blueprint documentation with the Facilities Management Support at 1:15 p.m. on 03/17/25, the construction type for the facility was Type V(111). In addition, a two-hour fire barrier wall is constructed from the	K 0161	K161 - Building Construction Type and Height Compliance Date: 04/04/2025 Corrective Action: The Director of Plant Operations replaced the striker and strike plate on 90-min door separating the main dining room from the restorative dining room. **Exhibit A – Photo** The Director of Plant Operations	04/04/2025

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	floor to the underside of the roof in the wall separating the Main Dining Room from the Health Club and the Restorative Dining Room. Based on observations with the Facilities Management Support, the Assistant Director of Plant Operations and the Maintenance Assistant at 2:20 p.m. on 03/17/25, the door separating the Main Dining Room from the Restorative Dining Room is in the two-hour fire barrier wall noted in the facility blueprints. The door was equipped with a self-closing device and was held in the fully open position with a wall mounted magnetic holding device set to release with fire alarm activation. A 90-minute fire resistance rating label was affixed to the hinge side of the door. The door failed to fully self-close and latch into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Assistant Director of Plant Operations and the Maintenance Assistant agreed the aforementioned door in the two-hour fire barrier wall failed to fully self-close and latch into the door frame which did not maintain the building construction type. These findings were reviewed with the Administrator and the Facilities Management Support during the exit conference. 3.1-19(b)		was educated by the Executive Director K161 – NFPA 101, 2012 edition Building Construction Type and Height 19.1.6.1, 19.1.6.2 through 19.1.6.7, 19.1.6.4, 10.1.6.5 **Exhibit B – Inservice** The Director of Plant Operations or designee will audit 90 min doors in facility daily x 4 weeks then weekly x 3 months, assuring that each door properly self-closes and latch. **Exhibit C – Audit tool** Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Main Dining Room.	
K 0251 SS=D Bldg. 01	NFPA 101 Dead-End Corridors and Common Path of Travel Based on observation and interview, the facility failed to ensure 1 of 7 exit access corridors did not have a dead-end exceeding 30 feet. This deficient practice could affect two residents. Findings include:	K 0251	**K251 – Dead end Corridors and common Path of Travel** Compliance Date 04/04/2025 Corrective Action Exit signage was installed	04/04/2025

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	Based on interview at the time of the entrance conference at 10:00 a.m. on 03/17/25, the Administrator stated a new dialysis center was added to the facility within the last two years. The Administrator stated comprehensive care residents have customary access to the dialysis center which adjoins the comprehensive care portion of the facility. Based on observations with the Facilities Management Support, the Assistant Director of Plant Operations and the Maintenance Assistant at 2:42 p.m. on 03/17/25, six resident sleeping rooms at the south end of the 100 Hall had been converted to the dialysis center. The former resident sleeping rooms identified as 109 through 114 now comprise the dialysis center which is at the south end of the 100 Hall. The entrance to the dialysis center from the 100 Hall was not marked as a facility exit. The entrance door to the dialysis center at the south end of the 100 Hall was locked with a keypad which required a code to unlock the door. The code to unlock the door was not posted. The north end of the 100 Hall consists of the corridor door set of self-closing 20-minute fire resistance rated doors by Room 101 and 102 which do not latch into the door frame. As a result, residents in resident sleeping rooms 103, 104, 105, 106, 107 and 108 have only one exit access resulting in a dead end for two of those rooms. Based on observations at 2:45 p.m. on 03/17/25, the Assistant Director of Operations used a Keeson Walking Stick which measured the distance from the dialysis entrance door to the corridor door set by Room 101 as 42 feet. Based on interview at the time of the observations, the Facilities Management Support and the Assistant Director of Plant Operations agreed that a dead-end corridor of more than 30 feet was created for resident sleeping Room 107 and 108 by the conversion of the south end of the 100 Hall to a dialysis center which was not marked		indicating egress pathway the keypad code to enter Dialysis was posted above the keypad to allow entrance additional signage was added to the door to indicate entry must be staff assisted. **Exhibit D – Photo** **Exhibit E – Photo** The director of plant operations was educated by the Executive Director on K251 of the NFPA 101 code Section 19.2.5.2 as it pertains to dead end corridors and means of egress. **Exhibit B – Inservice** The director of Plant Operations will conduct a visual inspection of exit lighting to ensure proper location and illumination weekly x 4 then monthly X 3. **Exhibit F- Audit Tool** Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect 2 residents.	

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	as a facility exit for the 100 Hall. These findings were reviewed with the Administrator and the Facilities Management Support during the exit conference. 3.1-19(b)			
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Based on observation and interview, the facility failed to ensure egress lighting for 1 of 8 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect over 10 residents, staff and visitors if needing to exit the facility from the 600 Hall by Room 617. Findings include: Based on observations with the Facilities Management Support, the Assistant Director of Plant Operations and the Maintenance Assistant at 2:58 p.m. on 03/17/25, the exit discharge for the 600 Hall by Room 617 was equipped with one lighting fixture with two light bulb sockets for the fixture but only one light bulb was in the fixture. Based on interview at the time of the observations, the Facilities Management Support agreed the aforementioned exit discharge was not arranged with the minimum number of operable lighting fixtures (bulbs). These findings were reviewed with the	K 0281	K281 - Illumination of Means of Egress Compliance Date: 04/04/2025 Corrective Action: The Director of Plant Operations replaced the missing light bulb in fixture near exit discharge for the 600 hall, by room 617 **Exhibit G - Photo** The DPO (Director of Plant Operations) was educated by the Executive Director on K281 Illumination of Means of Egress LSC 7.8.1.4 requires illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0,2 foot-candle in designated area. **Exhibit B - Inservice** The Director of Plant Operations or Assignee will audit exterior lights weekly x 4wks then monthly X 3 mths. **Exhibit H – Audit tool** Results of this audit will be	04/04/2025

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	Administrator and the Facilities Management Support during the exit conference. 3.1-19(b)		presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect over 10 residents, staff and visitors if needing to exit the facility from the 600 Hall by Room 617.	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Based on observation and interview, the facility failed to ensure 1 of 6 battery powered emergency lighting systems was maintained in accordance with LSC Section 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70, National Electric Code. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Facilities Management Support, the Assistant Director of Plant Operations and the Maintenance Assistant at 1:51 p.m. on 03/17/25, the battery operated lighting system installed on the ceiling above the emergency generator transfer switches in the facility's main electrical room by the employee break room failed to illuminate when its respective	K 0291	K291 Emergency Lighting Compliance date 04/04/2025 Corrective Action: The Director of Plant Operations replaced one battery operated emergency light in the main mechanical room. **Exhibit I - Photo** The Director of Plant Operations was educated by the Executive Director on Emergency Lighting, Emergency Lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9.18.2.9.1 19.2.9.1 **Exhibit B – Inservice** The Director of Plant operations will test the operation of the emergency lighting in the mechanical 1 X per week X 2 months.	04/04/2025

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	test button was pushed multiple times. Based on interview at the time of the observations, the Maintenance Assistant agreed the battery operated lighting system failed to illuminate when it was tested multiple times. These findings were reviewed with the Administrator and the Facilities Management Support during the exit conference. 3.1-19(b)		**Exhibit J – Audit Tool** Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect staff in the facility.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Facilities Management Support at 9:50 a.m. on 03/17/25 during the entrance to the facility, which comprised a part of the initial walk through of the facility, the remote fire alarm control panel at the main entrance door for the health care portion of the facility was in the trouble mode and was silenced. The remote panel did not state the cause of the trouble. Based on interview at the	K 0345	K345: FIRE ALARM SYSTEM – TESTING & MAINTENANCE Compliance Date: 4/04/2025 Corrective Action: The Director of Plant Operations has contacted Safe Care and remedy the trouble signal on the fire alarm control panel. The Director of Plant Operations was educated by the Executive Director on Fire Alarm Systems testing and maintenance 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. **Exhibit B - Inservice** The Director of Plant Operations or Designee will audit fire panel to ensure panel does not display any	04/04/2025

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	time of the observations, the Facilities Management Support stated he was visiting the facility that day and did not know it was in the trouble mode or the cause of the trouble. Based on interview at the time of the observations, the Facilities Management Support stated he would contact the fire alarm inspection contractor immediately for a site visit for repair. Based on observations with the Facilities Management Support at 2:26 p.m. on 03/17/25, the facility's main fire alarm control panel at the Health Center nurse's station was still in the trouble mode and was silenced. Based on interview at the time of the observations, the Facilities Management Support stated the fire alarm system contractor had come to repair the system and found that a duct detector in the Health Club more than likely needed repair or additional parts and was not corrected at the time of the survey. These findings were reviewed with the Administrator and the Facilities Management Support during the exit conference. 3.1-19(b)		trouble signals once daily X 4 weeks, then 1 X per day every other week X 2 months. **Exhibit K – Audit tool** Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all residents, staff and visitors.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to ensure 1 of 19 portable fire extinguishers in the facility were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall	K 0355	K 355 - Fire Extinguishers Compliance date: 4/04/2025 Corrective Action The Director of Plant Operations Immediately removed the spare fire extinguisher from the mechanical room and mounted it on the wall off the floor in the sprinkler riser room. **Exhibit L – Photo**	04/04/2025

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	recess. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the 600 Hall sprinkler riser room. Findings include: Based on observation with the Facilities Management Support, the Assistant Director of Plant Operations and the Maintenance Assistant at 3:02 p.m. on 03/17/25, the ABC portable fire extinguisher located in the 600 Hall sprinkler riser room was not supported and was free standing on top of the water softener storage bin. The portable fire extinguisher inspection contractor had affixed an annual maintenance tag indicating annual maintenance was performed in November 2024. The facility had documented monthly inspections on the tag through March 2025. Based on interview at the time of the observation, the Facilities Management Support agreed the fire extinguisher was freestanding on top of the bin and was not properly installed. These findings were reviewed with the Administrator and the Facilities Management Support during the exit conference. 3.1-19(b)		The Director of Plant Operations was educated by the Executive Director on NFPA 101, Portable Fire Extinguishers. Portable Fire Extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12. 19.3.5.12, NFPA 10 **Exhibit B - Inservice** The Director of Plant Operations or designee will audit the Portable Fire Extinguishers located in the sprinkler riser room, assuring that it remains securely mounted to the wall 1 X per week X 6 weeks. **Exhibit M – Audit tool** Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect over 10 residents, staff and visitors, in the vicinity of the 600 Hall sprinkler riser room.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of over 50 corridor doors to	K 0363	K363 Corridor - Doors Compliance date 04/04/2025	04/04/2025

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	resident sleeping rooms had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors in the vicinity or resident sleeping Room 308. Findings include: Based on observation with the Facilities Management Support, the Assistant Director of Plant Operations and the Maintenance Assistant at 1:56 p.m. on 03/17/25, the corridor door to resident sleeping Room 308 was propped in the fully open position with a wedge placed on the floor under the door. Based on interview at the time of the observation, the Facilities Management Support stated the resident's family brought the wedge in to the facility and agreed the aforementioned corridor door had an impediment to latching into the door frame and would not resist the passage of smoke. These findings were reviewed with the Administrator and the Facilities Management Support during the exit conference. 3.1-19(b)		Corrective Action The Director of Plant Operations has removed the wedge that was propping open resident sleeping Room 308. The Director of Plant Operations was educated by the Executive Director on NFPA 101, 2012 edition, Corridor – Doors 19.3.6.3.10. Doors shall not be held open by devices other than those that release when the door is pushed or pulled. **Exhibit B - Inservice** The Director of Plant Operations will audit all Resident room doors 1 x per week x 4 weeks **Exhibit N – Audit tool** Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect over 20 residents, staff and visitors, in the vicinity of resident room 308.	
K 0712 SS=F	NFPA 101 Fire Drills			

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Bldg. 01	Based on record review and interview, the facility failed to document quarterly fire drills on the third shift for 1 of 4 quarters. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Fire Drill Report" documentation and Direct Supply TELS "Fire Drills" documentation with the Facilities Management Support and the Assistant Director of Plant Operations at 11:05 a.m. on 03/17/25, documentation of a fire drill conducted within the most recent twelve month period on the third shift in the fourth quarter (October, November, December) 2024 was not available for review. The facility documented two fire drills conducted on the second shift at 4:19 p.m. on 11/30/24 and at 2:30 p.m. on 12/30/24. Based on interview at 11:05 a.m. on 03/17/25, the Facilities Management Support stated the facility operates three shifts per day and confirmed the 11/30/24 4:19 p.m. fire drill was a second shift fire drill. The Facilities Management Support provided documentation of a third shift fire drill conducted on 01/06/25 at 5:41 a.m. which he agreed was not conducted during the fourth quarter of 2024. Based on interview at the time of record review, the Facilities Management Support stated additional fire drill documentation was not available for review and agreed documentation of a fire drill conducted on the third shift in the fourth quarter 2024 was not available for review. These findings were reviewed with the Administrator and the Facilities Management Support during the exit conference. 3.1-19(b)	K 0712	K712 Fire Drills Compliance Date: 04/04/2025 Corrective action: Director of Plant Operations created schedule for fire drills for 2025 to ensure drills are held at unexpected times that vary monthly for all staff on all shifts. The Director of Plant Operations was educated by the Executive Director on NFPA 101 – Fire Drills. Fire Drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. **Exhibit B - Inservice** The Director of Plant Operations will monitor fire drill schedule monthly to ensure drills are held at unexpected and varying times. Results of the monitoring will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all residents, staff and visitors.	04/04/2025

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	155678	A. BUILDING 01 B. WING	03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

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K 0911 SS=F Bldg. 01	3.1-51(c) NFPA 101 Electrical Systems - Other Based on observation and interview, the facility failed to identify protected branch circuits for 2 of over 10 electrical panels in the facility in accordance with NFPA 70. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 210.5(A) states the grounded conductor of a branch circuit shall be identified in accordance with Article 200.6. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Facilities Management Support, the Assistant Director of Plant Operations and the Maintenance Assistant at 1:56 p.m. on 03/17/25, most all of the overcurrent devices that were in the "On" position in the wall mounted electrical panel identified as "A.D. Critical" in the main electrical room by the breakroom were not identified. The only overcurrent devices identified in the panel were breakers 16 through 20 which were identified as "Sewage Pump". The "A.D. Critical" electrical panel was also on the facility's emergency generator as electrical conduits for the panel were connected to the adjoining Russell Electric Automatic Transfer Switch in the room. Based on interview at the time of the observations, the Maintenance Assistant agreed the electrical panel was also on the emergency generator with most all overcurrent devices not identified. In addition, the main electrical shut offs in the room also	K 0911	K911 Electrical System-Other Compliance Date: 4/04/2025 Corrective Action: The Director of Plant Operations has contacted and scheduled Houston Electric to trace Breakers and label them inside 2 of 10 electric panels in the facility. The Director of Plant Operations was educated by the Executive Director on Electrical Systems-Other NFPA 70, 2011 edition article 210.5(A) state the grounded conductor of a branch circuit shall be identified in accordance with Article 200.6 **Exhibit B - Inservice** The Director of plant Operations will perform an audit of the 2 electrical panels assuring that the ground conductor of a branch circuit remains identified. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all residents, staff and visitors.	04/04/2025

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	indicated a subpanel identified as "SEM" was located in the facility. Based on observations with the Facilities Management Support, the Assistant Director of Plant Operations and the Maintenance Assistant at 3:01 p.m. on 03/17/25, most all of the overcurrent devices that were in the "On" position in the wall mounted electrical panel identified as "SEM" in the 600 Hall sprinkler riser room were not identified. The only overcurrent device which was identified in the panel was breaker 25 which was identified as "Fire Alarm Booster". The exterior shell of the "SEM" panel had "Emergency Panel ICS" hand written on the panel. Based on interview at the time of the observations, the Assistant Director of Plant Operations and the Maintenance Assistant agreed all overcurrent devices for the "SEM" panel did not identify the circuits protected by the device except for breaker 25. These findings were reviewed with the Administrator and the Facilities Management Support during the exit conference. 3.1-19(b)			
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Based on record review and interview, the facility failed to ensure documentation of electrical outlet receptacle testing for all resident sleeping rooms was completed 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 Electrical Systems-Maintenance and Testing Compliance Date: 4/04/2025 Corrective Action: The Director of Plant Operations has Re-Tested all receptacles to ensure that the Ground Retention tests were performed. Director of Plant Operations was educated by Facilities	04/04/2025

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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, staff and visitors. Findings include: Based on review of Direct Supply TELS "Receptacle Testing" documentation dated October 2024 with the Facilities Management Support and the Assistant Director of Plant Operations at 12:53 p.m. on 03/17/25, electrical receptacle inspection and testing documentation for all resident sleeping rooms within the most recent twelve month period was incomplete. The October 2024 inspection and testing documentation listed the room locations but did not itemize receptacle locations in each room. In addition, the "Ground Retention" column of the inspection documentation was left blank for each room. Based on interview at the time of record review, the Facilities Management Support stated the facility does perform ground force retention testing for the receptacles but agreed ground force retention testing documentation for the receptacles was not available for review and		Management Support on NFPA 99, 2012 edition, 6.3.4.1.3 states receptacles not listed as hospital – grade at patient bed locations shall be tested at intervals not exceeding 12 months. Exhibit B - Inservice The Director of Plant Operations will audit outlets in the Campus assuring that each non- Hospital – Grade electrical receptacle has been inspected and not exceeding 12 months Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all residents, staff and visitors	

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	agreed "Receptacle Testing" documentation was not itemized by receptacle location within the resident sleeping rooms. Based on interview at the time of record review, the Facilities Management Support stated each resident sleeping room may have a mix of hospital grade and non-hospital grade receptacles installed in the room. These findings were reviewed with the Administrator and the Facilities Management Support during the exit conference. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a properly located remote stop in the event the generator caught fire. NFPA 110, Standard for Emergency and Standby Power Systems 2010 Edition, Section 5.6.5.6, requires all installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. Section 5.6.5.6.1, requires the remote manual stop station to be labeled. Annex A is not a part of the requirements but is included for informational purposes only. A.5.6.5.6 states for systems located outdoors, the manual shutdown should be located external to the weatherproof enclosure and should be appropriately identified. This deficient practice could affect all residents, staff and visitors in the	K 0918	K918 - Electrical Systems-Essential Electric Style Compliance Date: 04/04/2025 Corrective Action: The Director of Plant Operations contacted Houston Electric on 3/20/2025 to install remote Emergency Shut-Off Switch to inside mechanical room for the Generator. The Director of Plant Operations was educated by the Executive Director on NFPA 110, Standard for Emergency and Standby Power Systems 2010 edition, Section 5.6.5.6, requires all installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing of the prime mover, where	04/04/2025

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	facility. Findings include: Based on observations with the Facilities Management Support, the Assistant Director of Plant Operations and the Maintenance Assistant at 1:52 p.m. on 03/17/25, the facility has one diesel fired emergency generator located outside of the building in a weatherproof shell on the north side of the property. Manufacturer's nameplate documentation affixed to the emergency generator stated it was rated at 100 kW and was manufactured 04/20/23. No remote stop for the emergency generator could be located on the exterior of the weatherproof shell or in a remote location inside or outside the facility. Based on interview at the time of the observations, the Facilities Management Support and the Maintenance Assistant stated the generator was a replacement generator for their old generator and agreed no remote stop switch was installed for this new generator. These findings were reviewed with the Administrator and the Facilities Management Support during the exit conference. 3.1-19(b)		so installed, or elsewhere on the premises where the prime mover is located outside the building. Section 5.6.5.6.1 requires the remote manual stop station to be labeled. **Exhibit B – Inservice** The Director of Plant Operations will audit the newly installed remote manual stop station that this device remains visible, unblocked, and as appropriate signage. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all residents, staff and visitors.	