STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155443	A. BUILDING -- B. WING	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF MUNCIE, THE	2400 CHATEAU DR MUNCIE, IN 47303

(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: 04/22/25 Facility Number: 000310 Provider Number: 155443 AIM Number: 100288970 At this Emergency Preparedness survey, The Waters of Muncie was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 72 certified beds. At the time of the survey, the census was 44. Quality Review completed on 04/25/25	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.	
E 0006 SS=C Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418 Plan Based on All Hazards Risk Assessment Based on record review and interview, the facility failed to maintain an emergency preparedness plan (EPP) that was based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients and included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.475(a) (1) and 42 CFR 483.475(a) (2). This deficient practice could affect all occupants. Findings include:	E 0006	E006– It is the intent of the facility to ensure to maintain an emergency preparedness plan that is based on and includes a documented, facility based and community-based risk assessment, utilizing an all hazards approach, including missing residents and included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.475 (a) (1) and	05/22/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robin Huston	Administrator	05/21/2025

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	Based on records review and interview with the Administrator (AD) and the Maintenance Director (MD) on 04/22/25 at 11:20 a.m., no documentation could be found regarding a documented facility-based and community-based risk assessment utilizing an all-hazards approach. This finding was acknowledged by the MD and AD at the time of observation and again at the exit conference with the MD and Administrator present.		42 CFR 483.475(a) (2) to meet set standards. 1 Corrective Action Taken: a On 5/05/2025 the Maintenance Supervisor, DON and the Administrator updated the emergency preparedness plan and includes a documented, facility based and community-based risk assessment, utilizing an all hazards approach which is reviewed annually to meet set standards. The Administrator verified the work 5/05/2025. 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 5/08/2025 and 5/10/2025 the Administrator inserviced the Maintenance Supervisor/DON/designee and all staff on the requirement that the emergency preparedness plan must include a facility based and community-based risk assessment, utilizing an all hazards approached and reviewed annually to meet set standards. b The Maintenance Supervisor/DON/Administrator/designee will ensure the emergency preparedness plan must include a facility based and community-based risk assessment, utilizing an all hazards approached and reviewed	

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			annually to meet set standards. c The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. 4 Monitoring Corrective Action: a The Administrator and Maintenance Supervisor/DON/designee will review the Emergency Preparedness Policy Manual and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. 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 5/22/2025.	
E 0037 SS=C Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(EP Training Program Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC	E 0037	E037 – It is the intent of the facility to ensure to conduct annual training for the Emergency	05/22/2025

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	facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on records review and interview with the Administrator (AD) and the Maintenance Director (MD) on 04/22/25 at 1:40 p.m., no documentation of annual EEP training and no documentation to show staff could demonstrate knowledge of the EPP was available for review. Based on an interview at the time of records review, the AD stated the training documentation was blank. This finding was acknowledged by the MD and AD at the time of observation and again at the exit conference with the MD and Administrator present.		Preparedness Program (EPP) to meet set standards. **1** Corrective Action Taken: On 5/08/2025 and 5/10/2025 the Administrator and Maintenance Supervisor/DON/designee completed an inservice sheet with the documentation and staff acknowledgment to demonstrate knowledge of the EPP training 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 Reoccurance: a On 5/05/2025 the Administrator inserviced the DON/ Maintenance Supervisor/All department heads / designee on the requirement to ensure all staff demonstrate knowledge of the EPP trainings to meet set standards. b DON/Maintenance Supervisor/ All department heads / designee will work with the Administrator to ensure all staff demonstrate knowledge of the EPP trainings to meet set standards. If any issues are discovered, they will be addressed and resolved immediately. c The Administrator will monitor adherence to the Emergency Preparedness Policy	

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			Manual and validate the documentation is in place. **4** Monitoring Corrective Action: At least annually to ensure compliance, the Administrator and DON/Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual and conduct required exercises and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. 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 5/22/2025.	
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).	K 0000	Disclaimer Statement: Preparation and/or execution of this plan of correction in general, or this corrective action, does not	

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	Survey Date: 04/22/25 Facility Number: 000310 Provider Number: 155443 AIM Number: 100288970 At this Life Safety Code survey, The Waters of Muncie 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 sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery powered smoke detectors in all resident sleeping rooms. The healthcare portion of the facility has a capacity of 72 and had a census of 44 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except for one garage used for storage and a shed used for smoking. Quality Review completed on 04/25/25		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.	
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other Based on observation and interview, the facility failed to ensure 1 of 1 laundry area dryer rooms was free of lint and other debris. LSC 19.1.1.3.1 states all health care facilities shall be designed, constructed, maintained and operated to minimize	K 0100	K100– It is the intent of the facility to ensure laundry area dryer rooms are free of lint and other debris to meet set standards. 1.Corrective Actions Taken:	05/22/2025

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	the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect mostly 3 laundry staff. Findings include: Based on observation and interview with the Maintenance Director (MD) on 04/22/25 at 1:05 p.m., the area behind the dryers in the laundry area was substantially covered with dryer lint. Additionally, several boxes and other combustible material was being stored behind the three gas fired dryers. The MD agreed that there was combustible material behind the dryers. This finding was acknowledged by the MD at the time of observation and again at the exit conference with the MD and Administrator present. 3.1-19(b)		a On 5/02/25 the Maintenance Supervisor cleaned the lint from the area behind the dryers in the laundry area and also removed the boxes and other combustible material that was being stored behind the dryers to meet set standards. The Administrator verified the work on 5/05/25 . 2 Al All Others with Potenial 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 5/05/25 the Administrator inserviced the Maintenance Supervisor/All laundry staff/designee on the requirement to ensure laundry area dryer rooms are kept free of lint and other debris to meet set standards. b Maintenance Supervisor/ Laundry Supervisor/designee will ensure laundry area dryer rooms are kept free of lint and other debris as a part of the facility's weekly 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.	

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			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 5/22/25.	
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through all exits 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	K 0222	K222– It is the intent of the facility to ensure the means of egress through exit doors are readily accessible for residents without a clinical diagnosis requiring specialized security measures to meet set standards.	05/22/2025

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	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 if needing to exit the facility. Findings include: Based on observation and interview with the Maintenance Director (MD) on 04/22/25 the following exit doors marked as facility exits, were magnetically locked and could be opened by entering a four-digit code but the code was not posted at the exits; a) at 10:25 a.m. the front door in the main lobby. b) at 12:30 p.m. exit door near RR# 404. c) at 12:35 p.m. the code posted at the employee exit door was incorrect. d) at 12:47 p.m. the exit door near RR# 312. e) at 1:06 p.m. exit door in the service hall. f) at 1:07 p.m. both exit doors from the dining room. This finding was acknowledged by the MD at the time of observation and again at the exit conference with the MD and Administrator present. 3.1-19(b)		1 Corrective Actions Taken: a On 5/05/25 the Maintenance Supervisor/designee posted the information on how to obtain the code on the following 6 exit doors 1. Front door in the main lobby 2. Exit door near RR#404 3. Employee exit door 4. Exit door near RR# 312 5. Exit door in the service hall and 6. Both exit doors from the dining room to meet set standards. The Administrator verified the work on 5/05/25. 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. On 5/05/25 the Maintenance Supervisor/designee inspected all doors and found no other negative findings. 3 Measures to Prevent Reoccurrence: a On 5/08/25 and 5/10/2025 the Administrator inserviced the Maintenance Supervisor/all staff/designee to ensure codes are posted at exit doors to meet set standards. b Maintenance Supervisor/designee will ensure codes are posted at exit doors as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be	

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			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 5/22/2025.	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits			

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	Based on observation and interview, the facility failed to ensure 1 of over 5 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect 13 residents and staff. Findings include: Based on observation and interview with the Maintenance Director (MD) on 04/22/25 at 12:33 p.m. the exit discharge near Resident Room #404, had large cracks and was uneven where the landing seemed on the sidewalk creating a trip hazard. The MD stated that the walkway would need to be repaired. This finding was acknowledged by the MD at the time of observation and again at the exit conference with the MD and Administrator present. 3.1-19(b)	K 0271	K271– It is the intent of the facility to ensure exit discharges have a level walking surface, are free of obstructions, and constructed of hard packed all weather travel surface in accordance with CMS Survey and certification letter 05-38 to meet set standards. 1 Corrective Actions Taken: a On or before 5/22/2025 the Maintenance Supervisor/designee repaired the large crack and uneven area at the landing at the sidewalk at the exit discharge near resident room 404 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 5/05/2025 the Administrator inserviced the Maintenance Supervisor to ensure exit discharges and walkway are readily accessible to meet set standards. b Maintenance Supervisor/designee will inspect all exit discharge and walkways to ensure they are readily accessible as a part of the facility's Monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be	05/22/2025

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			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 on or before 5/22/2025.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure 1. Based on observation and interview, the facility	K 0321	K321– It is the intent of the facility	05/22/2025

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	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 6 staff and visitors. Findings include: Based on observation and interview with the Maintenance Director (MD) on 04/22/25 at 1:00 p.m., the corridor door to the kitchen, greater than 50 square feet and containing large trash receptacles, equipped with a self-closing device failed to latch into the door frame. The kitchen staff stated that the door might latch if you leave it alone for a few minutes. This finding was acknowledged by the MD at the time of observation and again at the exit conference with the MD and Administrator present. 2. Based on observation and interview, the facility failed to ensure 1 of 3 furnace rooms on the service hall that contained fuel fired equipment were separated from other spaces by smoke resistant partition/walls. This deficient practice could affect 15 staff, residents or visitors. Findings include: Based on observation and interview with the Maintenance Director (MD) on 04/22/25 at 1:05 p.m., the Service Hallway furnace room had a hole approximately 30 inches X 12 inches where the condensation drain penetrated the wall, exposing the wall studs. This finding was acknowledged by the MD at the time of observation and again at the exit conference with the MD and Administrator present.		to ensure hazardous area doors, such as storage rooms, are provided with properly working self-closing devices and to ensure furnace rooms on the service hall that contained fuel fired equipment area separated from other spaces by smoke resistant partition/walls to meet set standards. 1 Corrective Actions Taken: a On 5/06/2025 the Maintenance Supervisor/designee repaired the self-closing device on the corridor door to the kitchen to ensure it self closes and latches into the door frame to meet set standards. The Administrator verified the work on 5/05/2025 . b On 5/07/2025 the Maintenance Supervisor/designee repaired the hole in the service hallway furnace wall with a one hour fire rated material to ensure no penetrations to meet set standards. The Administrator verified the work on 5/07/2025. 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 5/05/2025 the Administrator inserviced the Maintenance Supervisor/ designee on the requirement to ensure hazardous areas are provided with	

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	3.1-19(b)		properly working self-closing devices and have no penetrations to meet set standards. b Maintenance Supervisor/designee will ensure hazardous areas are provided with properly working self-closing devices and have no penetrations as a part of the facility's monthly 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	

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	155443	A. BUILDING 01 B. WING	04/22/2025

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			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 5/22/2025.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 2 of over 8 electrical panels in the corridors were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect 15 staff and residents. Findings include: Based on observation and interview with the Maintenance Director (MD) on 04/22/25 at 12:25 p.m., two electrical panels near Resident Room # 407 were unlocked when tested. The MD was surprised these two panels were not locked. This finding was acknowledged by the MD at the	K 0511	K511– It is the intent of the facility to ensure electrical panels in the corridors are secured from non-authorized personnel to meet set standards. 1 Corrective Action Taken: a On 4/22/2025 the Maintenance Supervisor/designee locked the two electrical panels near resident room 407 to meet set standards. The Administrator verified the work on 4/22/2025. 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. Maintenance Supervisor checked all other areas and found no other negative findings. 3 Measures to Prevent Reoccurrence: a On 4/22/2025 the Administrator inserviced the Maintenance Supervisor/designee on the requirement to ensure electrical panels in the corridors	05/22/2025

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	time of observation and again at the exit conference with the MD and Administrator present. 3.1-19(b)		are secured from non-personnel to meet set standards. b Maintenance Supervisor/designee will ensure electrical panels in the corridors are secured from non-personnel as a part of the facility's weekly 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.	

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			This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/22/2025.	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC Based on observation and interview, the facility failed to ensure egress corridors were not used as a portion of a return air system serving adjoining rooms for 52 of 52 resident rooms in the egress corridors. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, Section 4.3.12.1.1 states egress corridors in nursing and long term care facilities shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas unless otherwise permitted by 4.3.12.1.3.1 through 4.3.12.1.3.4. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on observation and interview with the Maintenance Director (MD) on 04/22/25 at 12:10 p.m. and observations throughout the afternoon during the facility tour, all resident rooms were using the egress corridor as a return air system. Based on interview at the time of the observations, the MD verified the resident rooms were using the egress corridor as a return air system. The MD commented, "heat in the resident rooms was cable ceiling, there was a single air	K 0521	K521 – The facility has submitted an annual waiver request. Documentation has been uploaded to include waiver request, floor plan, and documentation of hardship.	05/22/2025

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	supply register in each resident room and no return." This finding was acknowledged by the MD at the time of observation and again at the exit conference with the MD and Administrator present. 3.1-19(b)			
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of at least 1 fire door assembly was 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 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	K 0761	K761 – It is the intent of the facility to ensure an annual inspection and testing of at least 1 fire door assembly is 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 permitted only in corridors and shall be protected by approved self-closing fire door assemblies to meet set standards. 1 Corrective Actions Taken: a On 5/07/2025the Maintenance Supervisor conducted the annual inspection of the oxygen transfilling room fire door assembly and documented the results in the Life Safety Binder to meet set standards. The Administrator verified the work on 5/07/2025. 2 All Others with Potential to be Affected: a All residents and all staff and visitors have the potential to	05/22/2025

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	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 14 residents. Findings include: Based on records review, interview and facility tour with the Maintenance Director (MD) on 04/22/25 at 11:25 a.m., no documentation of an annual inspection for the fire door assembly at the Oxygen Transfilling room was available for review. Based on observation during the tour the Oxygen Transfilling room has one 90-minute fire door assembly. Based on interview at the time of records review and observation, the Maintenance Supervisor stated the annual fire door inspection was not completed within the last year and was		be affected but none were. 3 Measures to Prevent Reoccurrence: a On 5/05/2025 the Administrator inserviced the maintenance Supervisor to ensure an annual inspection and testing of oxygen room fire door assembly is completed and documented to meet set standards. b Maintenance Supervisor/designee will ensure an annual inspection and testing of oxygen room fire door assembly is completed and documented as a part of the facility's annual 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	

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	previously unaware a fire door inspection was needed on the Transfilling Room door. This finding was acknowledged by the MD at the time of observation and again at the exit conference with the MD and Administrator present. 3.1-19(b)		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 5/22/2025.	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on records review, observation, and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development	K 0921	K921 – It is the intent of the facility to ensure to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE) to meet set standards. Corrective Actions Taken: On or before 5/16/2025 the facilities trained Regional Property Managers will conduct PCREE testing on the other PCREE in the facility including; electric beds, nebulizers, oxygen concentrators, vital sign monitors, and other electrical medical equipment to meet set standards. The Administrator verified the work on 5/16/2025 or before.	05/22/2025

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	of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents. Findings include: Based on records review, interview and facility tour with the Maintenance Director (MD) on 04/22/25 at 10:30 a.m., no documentation was available for review for the testing of the PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Observation during the building tour throughout the afternoon revealed that the facility provided electric beds for all residents. The MD stated that PCREE such as nebulizers, oxygen concentrators, vital signs monitors, and other electrical medical equipment was present and in use at the facility. This finding was acknowledged by the MD at the time of observation and again at the exit conference with the MD and Administrator present. 3.1-19(b)		All Others with Potential to be Affected: All residents and all staff and visitors have the potential to be affected but none were. Measures to Prevent Reoccurrence: On 5/05/2025 the Administrator inserviced the Maintenance Supervisor/DON/designee to ensure the testing of the PCREE is conducted and documented on all PCREE equipment to meet set standards. Maintenance Supervisor/designee will ensure testing of the PCREE is conducted and documented on all PCREE equipment as a part of the facility's annual 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. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. Monitoring Corrective Action; The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the	

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			Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QAPI) meeting. Inspection results and system components will be reviewed by the QAPI 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 5/22/2025.	
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 location was used properly and in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.5.2.3.1(1) states, (transfilling shall occur in) a designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. NFPA 99 2012 edition, 11.5.2.3.1 (4) the individual trans-filling the container(s) has been properly trained in the trans-filling procedures. This deficient practice could affect up to 20 residents in one smoke compartment. Findings include:	K 0927	K927– It is the intent of the facility to ensure oxygen storage/transfer location is used properly and in accordance with NFPA 99 to meet set standards. 1 Corrective Actions Taken: a On 5/06/2025 the DON/Maintenance Supervisor reconfigured the oxygen room to allow for oxygen transfer to take place with door closed to meet set standards. The Administrator verified the work on 5/06/2025 . 2 All Others with Potential to be Affected:	05/22/2025

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	Based on observation and interview with the Maintenance Director (MD) on 04/22/25 at 12:39 p.m., the facility's Oxygen Room was small and populated with liquid oxygen containers. There did not appear to be room for someone to do the transfilling procedure inside the room with the door closed. When asked, a QNA demonstrated how they would accomplish the procedure, and they held the door open with their leg. The QNA commented that the room was not large enough to do the transfilling procedure inside the room with the door closed. This finding was acknowledged by the MD at the time of observation and again at the exit conference with the MD and Administrator present. 3.1-19(b)		a All residents and all staff and visitors have the potential to be affected but none were. 3 Measures to Prevent Reoccurrence: On 5/05/2025 the Administrator inserviced the DON/and all nursing staff/Maintenance Supervisor to ensure door is able to be in the closed position when transfilling is occurring to meet set standards. Maintenance Supervisor/DON will ensure door is able to be in the closed position when transfilling is occurring as a part of the facility's Oxygen Policy and Procedures and document those inspections results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/DON/designee will review with the Administrator the inspection results. On 4 Monitoring Corrective Action: a The inspection results will be presented by the DON/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	

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			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 5/22/2025.	