STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155266	A. BUILDING -- B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN 46805

(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: 05/13/25 Facility Number: 000167 Provider Number: 155266 AIM Number: 100273740 At this Emergency Preparedness survey, Life Care Center of Fort Wayne was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 115 and had a census of 84 at the time of this survey. Quality Review completed on 05/19/25	E 0000	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Fort Wayne agrees with the allegations and citations listed. Life Care Center of Fort Wayne maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction.	
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 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	E 0037	**E037 EPP Training** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** -Associates will be re-educated on Emergency Preparedness which includes Policies, procedures, and demonstration of knowledge. .	06/13/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Holly Genry	Executive Director	05/29/2025

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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	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 with the Administrator and the Maintenance Director on 05/13/25 at 11:45 a.m., there was documentation of a sign-in sheet for EPP training dated 05/17/24, but there was no documentation of what the training consisted of and no documentation to show if staff could demonstrate knowledge of the EPP training. Based on an interview at 11:54 a.m., the Administrator and the Maintenance Director stated staff have been trained on the EPP but what the training consisted of and to show if staff could demonstrate knowledge of the EPP training was not documented. This finding was reviewed with the Administrator and Maintenance Director during the exit conference at 2:50 p.m.		***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** -All residents and associates have the potential to be affected by this deficient practice, therefore associates were re-educated on Emergency preparedness which includes Policy, procedures and demonstration of content. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** Associates have been re-educated on Emergency Preparedness, new associates will be trained on Emergency preparedness during orientation and re-educated annually there after. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** Executive Director and/or designee will conduct audits of the facility's inspection reports 1x per month for 6 months to ensure compliance. Any issues identified will be immediately addressed. The above stated audit results and system components will be reviewed by the QAPI Committee	

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			on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/13/25 Facility Number: 000167 Provider Number: 155266 AIM Number: 100273740 At this Life Safety Code survey, Life Care Center of Fort Wayne 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 III (200) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 115 and had a census of 84 at the time of this survey	K 0000	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Fort Wayne agrees with the allegations and citations listed. Life Care Center of Fort Wayne maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction.	

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	All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a maintenance office/workshop/storage building. Quality Review completed on 05/19/25			
K 0300 SS=C Bldg. 01	NFPA 101 Protection - Other Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of 63 of 63 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents. Findings include: Based on records review with the Maintenance Director on 05/13/25 at 11:08 a.m., the smoke alarm weekly check form listed all smoke alarms were tested, but the form was not itemized to ensure each smoke alarm was tested and/or cleaned. Based on interview 11:08 a.m., the Maintenance Director stated the alarms are tested weekly, but the smoke alarm documentation did not include each smoke alarm in each room.	K 0300	**K300 Protection** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** -Battery operated smoke detectors were tested weekly and a form was created to itemize each smoke detector . ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** -All residents and associates have the potential to be affected by this deficient practice. A form was created to itemize each smoke detector for testing. No issues were identified. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** Maintenance Director was educated on testing/cleaning of smoke detectors and these	06/13/2025

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	This was reviewed with the Administrator and Maintenance Director during the exit conference at 2:50 p.m. 3.1-19(b)		detectors must be itemized. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** Executive Director and/or designee will conduct audits of the facility's inspection reports 1x per week for 6 months to ensure compliance. Any issues identified will be immediately addressed. The above stated audit results and system components will be reviewed by the QAPI Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities (#1.) Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to the designed and installed positions for 1 of 1 kitchen hood extinguishing system. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2, states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system.	K 0324	**K324 Cooking facilities** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** Wheel Chock molded rubber stoppers were purchased for stove. Grease drip tray beneath stove hood was replaced . ***How other residents having the potential to be affected by the***	06/13/2025

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	Section 12.1.2.3 states the fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 states an approved method shall be provided that will ensure that the appliance is returned to an approved design location. (#2.) Based on observation and interview, the facility failed to provide grease drip trays for 1 of 1 kitchen hood systems. Cooking equipment is protected in accordance with NFPA 96, 6.2.4. Section 6.2.4.1states that grease filters shall be equipped with a grease drip tray beneath their lower edges. Section 6.2.4.2 states grease drip trays shall be kept to the minimum size needed to collect grease. Section 6.2.4.3 states that grease drip trays shall be pitched to drain into an enclosed metal container having a capacity not exceeding 3.8 L (1 gal). The deficient practices affects staff in the kitchen and 50 residents in the main dining room. Findings include: (#1.) Based on observation with the Administrator and the Maintenance Director on 05/13/25 at 1:10 p.m. the cooking equipment in the kitchen was covered by the fire suppression system, but the kitchen cooking appliances were not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for		***same deficient practice will be identified and what corrective action will be taken:*** Associates in dietary have the potential to be affected, therefore drip tray was replaced immediately, no negative outcomes ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** Maintenance staff along with dietary associates were re-educated on ensuing grease drip tray must be replaced immediately after cleaning ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** Executive Director and/or designee will conduct audits of the facility's inspection reports 2x per week for 6 months to ensure compliance. Any issues identified will be immediately addressed. The above stated audit results and system components will be reviewed by the QAPI Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.	

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	maintenance and cleaning. Based on an interview at 1:10 p.m., the Administrator and the Maintenance Director agreed the kitchen appliances were not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. (#2.) Based on observation with the Administrator and the Maintenance Director on 05/13/25 at 1:00 p.m. the kitchen was provided with a UL 300 hood system with grease filters but the grease drip tray beneath the lower edges of the hood was removed for cleaning and not replaced. Based on an interview at 1:00 p.m., the Administrator and the Maintenance Director agreed the hood system grease drip tray beneath the lower edges was missing. The findings were reviewed with the Administrator and Maintenance Director during the exit conference at 2:50 p.m. 3.1-19(b)			
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review 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 occupants.	K 0345	**K345 Fire Alarm System-Testing and maintenance** ***What Corrective Action will be accomplished for those residents found to have been affected by this*** deficient practice: Smoke detectors were tested on 5/19/2025 by safe care, smoke	06/13/2025

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	Findings include: Based on review of the annual fire alarm inspection dated 01/20/25 with the Maintenance Director on 05/13/25 at 11:00 a.m., stated 20 smoke detectors failed sensitivity testing and the detectors needed to be replaced. Based on an interview at 11:00 a.m., the Maintenance Director confirmed the failed testing on the fire alarm report and stated a quote has been given to replace the smoke detectors, but a date has not been scheduled. This was reviewed with the Administrator and Maintenance Director during the exit conference at 2:50 p.m. 3.1-19(b)		detectors passed sensitivity testing . ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** All residents and associates have the potential to be affected therefore a second company was contacted for an inspection. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** Maintenance associates were re-educated on understanding and importance of follow through with inspection reports that require attention ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** Executive Director and/or designee will conduct audits of the facility's inspection reports 1x per month for 6 months to ensure compliance. Any issues identified will be immediately addressed. The above stated audit results and system components will be reviewed by the QAPI Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. At that time, analysis of data will be done to	

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			ensure the deficient practice does not reoccur and/or adapt audit schedules.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads in 2 of 4 storage closets by the boiler room and 1 of 1 closets in room 108 were not obstructed in accordance with 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states that sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or non-continuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice affects 30 residents in two smoke compartments. Findings include: Based on observation with the Administrator and Maintenance Director on 05/13/25 at 11:48 a.m. and at 1:23 p.m., the two storage closets by the boiler room and the closet in room 108 had storage within 6 inches of the sprinklers. Based on interviews at 11:48 a.m. and 1:23 p.m., the Maintenance Director agreed the sprinkler heads in the closets were obstructed by storage. The findings were reviewed with the Administrator and Maintenance Director during the exit conference at 2:50 p.m.	K 0351	**K351 Sprinkler System-Installation** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** Upon identification of sprinklers heads obstructed, storage closets were immediately brought back to compliance of 18". . ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** All residents and staff have the potential to be affected, therefore an audit was completed of storage closets to ensure compliance. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** All associates were re-educated on obstruction of sprinkler heads. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:***	06/13/2025

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	3.1-19(b)		Executive Director and/or designee will conduct audits of the facility's inspection reports 2x per week for 6 months to ensure compliance. Any issues identified will be immediately addressed. The above stated audit results and system components will be reviewed by the QAPI Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.	
K 0511 SS=F Bldg. 01	NFPA 101 Utilities - Gas and Electric (#1.) Based on observation and interview, the facility failed to ensure 2 of 2 Ground Fault Circuit Interrupter (GFCI) receptacles in the front restroom and shower room by room 25 were properly maintained for protection against electric shock. 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, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault	K 0511	**K511 Utilities- Gas and Electric** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** All GFCI receptacles were tested. GFCI receptacles with identified areas of concern were replaced. A cover was immediately placed on junction box where there was an Electrical wire splice in service hall mechanical room. . ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:***	06/13/2025

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	circuit-interrupter protection for personnel. (1) Bathrooms, (2) Kitchens, (3) Rooftops, (4) Outdoors, (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. (6) Indoor wet locations, (7) Locker rooms with associated showering facilities, (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. (#2.) Based on observation, records review, and interview, the facility failed to ensure 120 of 120 GFCI receptacles were tested upon installation. LSC 6.3.3.4 Ground-Fault Protection Testing states when ground-fault protection is first installed, each level shall be performance-tested to ensure compliance with 6.3.2.5. (#3.) Based on observation and interview, the facility failed to ensure 1 of 1 electrical splices in the service hall mechanical room were made in a junction box. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. Article 322.56 (A) states splices shall be made in listed junction boxes. The deficient practices affects all residents. Findings include: (#1.) Based on observation with the Administrator and Maintenance Director on 05/13/25 at 11:25 a.m. and at 11:45 a.m., when the lobby restroom #1 and the shower room by room 25 GFCI receptacles were tested with a GFCI tester, the GFCI		All residents have the potential to be affected, therefore an initial audit was completed of GFCI receptacles and areas of concern were replaced. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** Maintenance associates were re-educated on initial testing of GFCI receptacles and annually there after. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** Executive Director and/or designee will conduct audits of the facility's inspection reports 1x per month for 6 months to ensure compliance. Any issues identified will be immediately addressed. The above stated audit results and system components will be reviewed by the QAPI Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.	

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	receptacles failed to trip and did not break the electrical circuit. Based on an interview at 11:25 a.m. and at 11:45 a.m., the Maintenance Director agreed the two GFCI electric receptacles did not properly work when tested. (#2.) Based on observation with the Administrator and Maintenance Director on 05/13/25 between 11:25 a.m. and at 2:10 p.m., each sink in the facility contained a GFCI receptacle within 6 feet of a water source. Based on records review at 2:30 p.m., there was no documentation of an initial GFCI receptacle testing. Based on an interview at 11:25 a.m. and at 2:10 p.m., the Maintenance Director stated it is unknown if the GFCI receptacles were tested. (#3.) Based on observation with the Administrator and Maintenance Director on 05/13/25 at 11:40 a.m. in the main mechanical room there was an electrical wire splice where an exit sign was removed that was not contained within a junction box. Based on an interview at 11:40 a.m., the Maintenance Director agreed there was an electrical splice that was not protected within a junction box. The findings were reviewed with the Administrator and Maintenance Director during the exit conference at 2:50 p.m. 3.1-19(b)			
K 0761 SS=F Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observations, records review, and interviews, the facility failed to ensure annual inspection and testing of 9 of 9 fire door assemblies and 1 of 1 oxygen room	K 0761	**K761 Maintenance, inspection & Testing- Doors** ***What Corrective Action will be accomplished for those***	06/13/2025

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	155266	A. BUILDING 01 B. WING	05/13/2025

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	fire doors was 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. (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 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.		***residents found to have been affected by this deficient practice:*** Fire doors along with oxygen transfilling room were tested on 5/20/25 with the itemized form with the required areas verified. . ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** All residents have the potential to be affected. Safe Care was contacted and itemized form was completed with fire doors. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** Maintenance was re-educated on Fire door inspections to include itemized areas and must include oxygen transfilling room. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** Executive Director and/or designee will conduct audits of the facility's inspection reports 1x per month for 6 months to ensure compliance. Any issues identified will be immediately addressed. The above stated audit results and system components will be reviewed by the QAPI Committee on a monthly basis with	

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	(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 observations with the Maintenance Director and the Administrator on 05/15/25 at 12:41 p.m., the oxygen transfilling room door was rated as a 45-minute fire door. Based on records review at 11:11 a.m., the documentation of the annual fire door inspection listed nine cross-corridor fire door assemblies were tested, but the forms were not itemized and did not indicate if the (11) required items were verified. Also, the oxygen transfilling room fire door was not listed as inspected. Based on an interview at 11:11 a.m., the Maintenance Director agreed the testing form was not itemized and stated the oxygen transfilling room fire door was not inspected. This was reviewed with the Administrator and Maintenance Director during the exit conference at 2:50 p.m. 3.1-19(b)		subsequent plans of correction developed and implemented as deemed necessary. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on records review, observation, and interview, the facility failed to maintain 1 of 1	K 0921	**K921 Electrical Equipment-Testing and Maintenance**	06/13/2025

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	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 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 with the Maintenance Director on 05/13/25 at 11:19 a.m., there was no documentation available for review to show testing of PCREE used in the facility.Based on observation from 11:30 a.m. to 2:00 p.m., each resident room contained PCREE such as electric beds, nebulizers, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment. Based on interviews at 11:20 a.m. and		***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** **Patient Care Related Electrical Equipment will be inspected, any areas of concern will be addressed immediately.** . ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** All residents have the potential to be affected. An initial audit of electrical beds, nebulizers, oxygen concentrators, air mattress pumps, IV pumps, all other electrical medical equipment was completed. Equipment will be initially tested, then retested if any modifications are made. Any areas of concern will be addressed immediately ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** Maintenance was educated on testing of Patient Care Related Electrical Equipment to be tested annually and if any modifications are made to PCREE.	

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	2:05 p.m. the Maintenance Director stated it was unknown if PCREE were inspected for physical integrity, resistance, leakage current, and touch current. This was reviewed with the Administrator and Maintenance Director during the exit conference at 2:50 p.m. 3.1-19(b)		***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** Executive Director and/or designee will conduct audits of the facility's inspection reports 1x per month for 6 months to ensure compliance. Any issues identified will be immediately addressed. The above stated audit results and system components will be reviewed by the QAPI Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.	