STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155695	A. BUILDING -- B. WING	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVERSIDE VILLAGE	1400 W FRANKLIN ST ELKHART, IN 46516

(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: 12/16/24 Facility Number: 003075 Provider Number: 155695 AIM Number: 200364160 At this Emergency Preparedness survey, Riverside Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 97 certified beds. At the time of the survey, the census was 70. Quality Review completed on 12/23/24	E 0000	K000 The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit.	
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: 12/16/24 Facility Number: 003075 Provider Number: 155695 AIM Number: 200364160 At this Life Safety Code survey, Riverside Village was found not in compliance with Requirements	K 0000	K000 The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tarshia Taylor	Executive Director	01/06/2025

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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	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 with a partial basement 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, spaces open to the corridors and battery operated smoke alarms were installed in the resident rooms. The building is fully protected by a 250 kW diesel powered emergency generator. The facility has a capacity of 97 and had a census of 70 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except a detached shed used for storage. Quality Review completed on 12/23/24			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure the corridor doors to 2 of 5 storage rooms which were hazardous areas containing combustible storage and greater than 50 square feet was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice affects staff in the basement. compartment. Findings include:	K 0321	**K321 – Hazardous Area Enclosure-** **What corrective action(s)will be accomplished for those residents found to have been affected by the deficient practice:** The first and last storage doors were repaired to latch into the door frame. **How other residents having the potential to be affected by the**	01/16/2025

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	Based on observations with the Maintenance Director on 12/16/24 at 2:31 p.m., the first and the last storage room on the north basement hall contained hazardous storage such as supplies and boxes, were greater than 50 square feet, were equipped with self-closing devices, but did not latch into the frames when tested. Based on interview at the time of observation, the Maintenance Director agreed the rooms were used as storage, were larger than 50 square feet, and stated the doors were not latching properly. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		**same deficient practice will be identified and what corrective actions will be taken:** All doors were inspected to ensure that the doors latched properly. **What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur:** The Maintenance Director was educated that all storage room doors that are larger than 50 sq ft with combustible material will have a door closer and latch into the frame The QAPI and monthly PM calendar was updated for the maintenance director to check that all doors latch properly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** The Executive Director and the Maintenance Director will round weekly prior to the completion date to ensure that all storage areas have doors that latch properly. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks are completed. **By what date the systemic changes will be completed:**	

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			1/16/25	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed ensure 1 of 1 cooktops open to the corridor met the requirements of LSC 19.3.2.5.3 which states within a smoke compartment, where residential or commercial cooking equipment is used to prepare meals for 30 or fewer persons, one cooking facility shall be permitted to be open to the corridor, provided that all of the following conditions are met: LCS TIA 12-2 19.3.2.5.3 states within a smoke compartment, where residential or commercial cooking equipment is used to prepare meals for 30 or fewer persons, one cooking facility shall be permitted to be open to the corridor, provided that all of the following conditions are met: (1) The portion of the health care facility served by the cooking facility is limited to 30 beds and is separated from other portions of the health care facility by a smoke barrier constructed in accordance with 19.3.7.3, 19.3.7.6, and 19.3.7.8. (2) The cooktop or range is equipped with a range hood of a width at least equal to the width of the cooking surface, with grease baffles or other grease-collecting and clean-out capability. (3)* The hood systems have a minimum airflow of 500 cfm (14,000 L/min). (4) The hood systems that are not ducted to the exterior additionally have a charcoal filter to remove smoke and odor. (5) The cooktop or range complies with all of the following: (a) The cooktop or range is protected with a fire suppression system listed in accordance with UL 300, or is tested and meets all requirements of UL 300A, in accordance with the applicable testing	K 0324	**K324- Cooking facilities-** **What corrective action(s)will be accomplished for those residents found to have been affected by the deficient practice:** The stove will be locked out to prevent use until such a time that the stove is permanently removed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** Any stove open to a corridor has been locked out to prevent use until the stove is removed. **What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur:** Maintenance Director has been educated on the requirements to have a cooktop open to the corridor. The QAPI and monthly PM calendar was updated for the maintenance director to check that all cooktops open to the corridor are locked out to prevent use or meet the regulation requirements.	01/16/2025

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	document's scope. (b) A manual release of the extinguishing system is provided in accordance with NFPA 96, Section 10.5. (c) An interlock is provided to turn off all sources of fuel and electrical power to the cooktop or range when the suppression system is activated. (6)* The use of solid fuel for cooking is prohibited. (7)* Deep-fat frying is prohibited (8) Portable fire extinguishers in accordance with NFPA 96 are located in all kitchen areas. (9)* A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. (c) The switch is on a timer, not exceeding a 120-minute capacity that automatically deactivates the cooktop or range, independent of staff action. (10) Procedures for the use, inspection, testing, and maintenance of the cooking equipment are in accordance with Chapter 11 of NFPA 96 and the manufacturer's instructions and are followed. (11)* Not less than two AC-powered photoelectric smoke alarms with battery backup, interconnected in accordance with 9.6.2.10.3, and equipped with a silence feature are located not closer than 20 ft (6.1 m) and not further than 25 ft (7.6 m) from the cooktop or range. (12)* The smoke alarms required by 19.3.2.5.3(11) are permitted to be located outside the kitchen area where such placement is necessary for compliance with the 20- ft (7.6-m) minimum distance criterion. (13)* A single system smoke detector is permitted to be installed in lieu of the smoke alarms required		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** The Executive Director will round with the Maintenance Director prior to the compliance date to ensure all stovetops are locked out to prevent use until removed. The Executive Director will review the preventative maintenance checks performed by the Maintenance Director monthly and sign off that checks were completed. **By what date the systemic changes will be completed:** **1/16/25**	

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	in 19.3.2.5.3(11) provided the following criteria are met: (a) The detector is located not closer than 20 ft (6.1 m) and not further than 25 ft (7.6 m) from the cooktop or range. (b) The detector is permitted to initiate a local audible alarm signal only. (c) The detector is not required to initiate a building-wide occupant notification signal. (d) The detector is not required to notify the emergency forces. (e) The local audible signal initiated by the detector is permitted to be silenced and reset by a button on the detector or by a switch installed within 10 ft (3.0 m) of the system smoke detector. (14) System smoke detectors that are required to be installed in corridors or spaces open to the corridor by other sections of this chapter are not used to meet the requirements of 19.3.2.5.3(11) and are located not closer than 25 ft (7.6 m) to the cooktop or range. This deficient practice could affect 40 residents in two smoke compartments. Findings include: Based on observations with the Maintenance Director on 12/16/24 at 12:10 p.m., the activity's cooktop stove was in a room with no separation from the corridor therefore making the cooktop open to the corridor and was not provided with the following: a) An extinguishing system with a manual release. b) A locked switch on a timer, not exceeding a 120-minute capacity that automatically deactivates the cooktop. c) A portable K-class fire extinguisher. Based on an interview at the time of observation, the Activities Director stated the cooktop is used to fry meat. The Maintenance Director agreed the			

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	cooktop was open to the corridor and were missing the aforementioned items. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0351 SS=C Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility did not provide adequate signage for 1 of 1 fire department connection (FDC). NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, 13.7 Fire Department Connections. 13.7.1 Fire department connections shall be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. This deficient practice could affect all residents. Findings include: Based on observation with the Maintenance Director and Administrator on 02/16/24 at 2:38 p.m., the FDC located at the back of the building was not provided with a FDC identification sign.	K 0351	**K351 -Sprinkler System Installation-** **What corrective action(s)will be accomplished for those residents found to have been affected by the deficient practice:** The FDC identification signage located at the back of the building was installed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** No other fire department connections to identify. **What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur:** The Maintenance Director was educated on proper placement of identifying FDC signage. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	01/16/2025

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	Based on interview at the time of observation, the Maintenance Director stated there was no identification sign on the FDC. This finding was reviewed with the Administrator and the Maintenance Director during the exit and the conference. 3.1-19(b)		**recur, i.e., what quality assurance program will be put in place:** The Maintenance Director was educated on proper placement of identifying FDC signage. The QAPI and monthly PM calendar was updated for the maintenance director to check that all Fire Department Connections are identified. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** The Executive Director will round with the Maintenance Director prior to the compliance date to ensure FDC identification signage is in view. The Executive Director will review the preventative maintenance checks performed by the Maintenance Director monthly and sign off that checks were completed. **By what date the systemic changes will be completed: 1/16/25**	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing (#1.) Based on observation and interview, the facility failed to maintain 1 of 2 ceiling constructions in the basement. The ceiling traps hot air and gases around the sprinkler and cause	K 0353	**K353 -Sprinkler System Maintenance and Testing** **What corrective action(s)will be accomplished for those**	01/16/2025

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	the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. (#2.) Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet large enough to fit all spare sprinkler heads, and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. The deficient practices could affect all residents. Findings include: (#1.) Based on observation with the Maintenance Director on 12/16/24 at 1:58 p.m., in the basement ceiling there was a 3'x3' uncovered hatch, a 4'x3' cut out by the storerooms and a 3'x1" crack in the small storeroom. This condition could delay the activation of the sprinklers installed in the ceiling. Based on an interview at the time of observation, the Maintenance Director agreed there were unsealed holes and gaps in the basement ceiling.		**residents found to have been affected by the deficient practice:** (1) The ceiling construction in the basement has been replaced. (2) A spare sprinkler cabinet stocked with all spare sprinkler heads and a sprinkler wrench was installed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All ceilings were inspected to ensure they were maintained. No other sprinkler systems located in the facility to inspect. **What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur:** (1) The Maintenance Director was educated on maintaining all ceilings and keeping a supply of spare sprinklers in a sprinkler cabinet that can hold all spare sprinklers and to have a sprinkler wrench available. The QAPI and PM monthly calendar was updated for the Maintenance Director to check that all ceilings are maintained, and spare sprinkler heads are stored properly with a special wrench available. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	(#2.) Based on observation with the Maintenance Director on 12/16/24 at 2:11 p.m., the spare sprinkler cabinet in the riser closet was not large enough to contain all sprinkler heads and prevent damage. When the cabinet in the riser closet was opened, the cabinet contained 12 spaces for sprinklers but contained 17 sprinkler heads. Based on an interview at the time of the observation, the Maintenance Director agreed the cabinet was not large enough to contain all spare sprinkler heads. The findings were reviewed with the Administrator and the Maintenance Director during the exit and the conference. 3.1-19(b)		**recur, i.e., what quality assurance program will be put in place:** The Executive Director will round with the Maintenance Director prior to the compliance date to ensure all ceilings are maintained and spare sprinkler heads are stored properly with a special wrench available. The Executive Director will review the preventative maintenance checks performed by the Maintenance Director monthly and sign off that checks were completed. **By what date the systemic changes will be completed: 1/16/25**	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 3 of 46 resident room corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 25 residents in two smoke compartments. Findings include: Based on observations with the Maintenance Director on 12/16/24 from 12:00 p.m. to 3:00 p.m., the corridor resident room doors to rooms 500, 502, and 403 were propped open with trash cans. Based on an interview at the time of observation, the Maintenance Director acknowledged the aforementioned corridor doors would not close	K 0363	**K363 -Corridor Doors-** **What corrective action(s)will be accomplished for those residents found to have been affected by the deficient practice:** The waste receptacles were removed from resident room doors. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All corridor doors were inspected to ensure there were no impediments to closing. **What measures will be put in**	01/16/2025

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	unless the trash cans were moved first. This finding was reviewed with the Administrator and the Maintenance Director during the exit and the conference. 3.1-19(b)		**place or what systemic changes will be made to ensure that deficient practice does not recur:** Staff were educated on propping doors and preventing them from closing/latching. The QAPI and PM monthly calendar was updated for the Maintenance Director to check that all corridor doors have no obstruction in their path. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** The Executive Director will round with the Maintenance Director prior to the compliance date to ensure that corridor doors are free from obstruction. The Executive Director will review the preventative maintenance checks performed by the Maintenance Director monthly and sign off that checks were completed. **By what date the systemic changes will be completed:** **1/16/25**	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure penetrations through 2 of 5 smoke barrier walls were protected to maintain the smoke	K 0372	**K372 –Subdivision of Building Spaces: Smoke Barriers-** **What corrective action(s)will be**	01/16/2025

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	resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect 50 residents in three smoke compartments. Findings include: Based on observation with the Maintenance Director on 12/16/24 at 2:30 p.m., in the attic by rooms 400 and 210 the smoke walls had six drywall patches over holes, but between the patches and the smoke walls there were unsealed gaps from 1/8 of an inch to one inch in size around the patches. Based on an interview at the time of observation, the Maintenance Director agreed there were drywall patches that were not sealed around the edges. The findings were reviewed with the Administrator and the Maintenance Director during the exit and the conference. 3.1-19(b)		**accomplished for those residents found to have been affected by the deficient practice:** All unsealed gaps in the attic by rooms 400 and 210 were sealed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All of the remaining smoke barrier walls were inspected for unsealed gaps and are in compliance. **What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur:** Maintenance Director was educated requiring that all smoke barrier walls remain maintained with no unsealed gaps. The QAPI and monthly calendar was updated for the Maintenance Director to review that all smoke walls are inspected for unsealed gaps and are in compliance with K372. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** The Executive Director will round with the Maintenance Director prior to the compliance date to ensure that the smoke barrier walls are sealed. The Executive	

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	155695	A. BUILDING 01 B. WING	12/16/2024

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			Director will review the preventative maintenance checks performed by the Maintenance Director monthly and sign off that checks were completed. **By what date the systemic changes will be completed: 1/16/25**	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 3 of 3 electrical splices 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. This deficient practice could affect 30 residents in two smoke compartments. Findings include: Based on observation with the Maintenance Director on 12/16/24 between 11:30 a.m. and 2:30 p.m., the following was discovered: (a.) In the attic by the marketing office there were electrical wires spliced together connected to an electric air vent that was not contained inside a junction box. (b.) In the attic by room 400 there was an electrical wire-end with exposed copper that was not contained inside a junction box. (c.) In the sprinkler riser closet there was a flexible conduit with exposed electrical wires that were not contained inside a junction box. Based on an interview at the time of the observations, the Maintenance Director agreed	K 0511	**K511 -Utilities-** **What corrective action(s)will be accomplished for those residents found to have been affected by the deficient practice:** (1) Junction box was added in the attic near the marketing office, by room four hundred, and in the sprinkler riser closet. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All areas were inspected for exposed wiring and junction boxes added where needed. **What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur:** The Maintenance Director was educated on ensuring all exposed wiring is contained in a junction	01/16/2025

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	there were electrical splices or wire-ends that were not protected within a junction box. The findings were reviewed with the Administrator and the Maintenance Director during the exit and the conference. 3.1-19(b)		box. The QAPI and monthly calendar was updated for the Maintenance Director to review that all exposed wiring is contained in junction boxes. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** The Executive Director will round the Maintenance Director prior to the compliance date to ensure that all exposed wires are contained in junction boxes. The Executive Director will review the preventative maintenance checks performed by the Maintenance Director monthly and sign off that checks have been completed. **By what date the systemic changes will be completed: 1/16/25.**	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on observation and interview, the facility failed to ensure 1 of 1 smoking areas and 1 of 1 non-smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect staff outside the kitchen and in the smoking area. Findings include:	K 0741	**K741- Smoking Regulations** **What corrective action(s)will be accomplished for those residents found to have been affected by the deficient practice:** All cigarette butts were removed and the proper container provided to dispose of the cigarette butts.	01/16/2025

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	Based on observation with the Maintenance Director on 12/16/24 between 12:18 p.m. and 3:00 p.m., the following cigarette butts were not properly disposed: a.) Outside the kitchen exit (a non-smoking area) there were 15 cigarette butts disposed onto the ground b.) In the staff smoking area there were over 20 cigarette butts disposed onto the ground and not into a plastic smokers' pole with no metal or non-combustible container. Based on an interview at the time of observations, the Maintenance Director agreed there were cigarette butts on the ground in both areas. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All areas were observed for cigarette butts disposed onto the ground. No other concerns noted. **What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur:** Staff were educated on proper disposal of smoking materials into approved containers and where the smoking areas are located around the facility. The QAPI and monthly calendar was updated for the Executive Director/Maintenance Director to inspect the smoking area to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** The Executive Director will round the Maintenance Director daily prior to the compliance date to ensure that the smoking area is free from improper smoking materials. The Executive Director will review the preventative maintenance checks performed by the Maintenance Director monthly and sign off that checks have been completed	

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			By what date the systemic changes will be completed: 1/16/25.	
K 0761 SS=B Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on records review and interview the facility failed to ensure annual inspection and testing of 6 of 6 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies 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,	K 0761	**K761-Maintenance, Inspections & Testing- Doors** **What corrective action(s)will be accomplished for those residents found to have been affected by the deficient practice:** The documentation for annual inspection for the oxygen room door were up-dated and completed using the 11 required items. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All fire doors were inspected using the 11 required items and documentation uploaded into TELS. **What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur:** The Maintenance Director was educated on having the annual inspection of fire doors using the 11 required items to be performed and the documentation uploaded into TELS The QAPI and monthly calendar	01/16/2025

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	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 25 residents in one smoke compartment. Findings include: Based on records review with the Maintenance Director on 12/16/24 at 10:19 a.m., the documentation of an annual inspection for the oxygen room fire door was marked as completed In the TELS computer system on 07/31/24, but the form did not indicate if the 11 required items were verified. Based on an interview at the time of records review, the Maintenance Director stated a checklist with the required items was used, but the checked items were not documented. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		was updated for the Maintenance Director to perform the annual inspection of fire doors using the 11 required items to be performed and the documentation uploaded into TELS **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** The Executive Director will round the Maintenance Director prior to the compliance date to ensure the annual inspection of fire doors using the 11 required items to be performed and the documentation uploaded into TELS. The Executive Director will review the preventative maintenance checks performed by the Maintenance Director monthly and sign off that checks have been completed. **By what date the systemic changes will be completed: 1/16/25.**	

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K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect staff in the basement. Findings include: Based on observation with the Maintenance Director on 12/16/24 at 1:36 p.m., in the sprinkler riser closet an extension cord was in use powering the air compressor. Based on an interview at the time of observation, the Maintenance Director agreed an extension cord was in use powering an air compressor. This finding was reviewed with the Administrator and the Maintenance Director during the exit and the conference. 3.1-19(b)	K 0920	**K920- Electrical Equipment-Power Cords and Extension Cords** **What corrective action(s)will be accomplished for those residents found to have been affected by the deficient practice:** The compressor has been hard wired into the panel box located in the sprinkler riser closet. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All areas were inspected to ensure no other flexible cords were used in place of fixed wiring. No other areas noted. **What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur:** The Maintenance Director was educated that flexible cords (extension cords) were not to be used as a substitute for fixed wiring. The QAPI and PM monthly calendar was updated for the Maintenance Director to review for use of flexible cords in place of fixed wiring **How the corrective action(s) will be monitored to ensure the**	01/16/2025

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			deficient practice will not recur, i.e., what quality assurance program will be put in place: The Executive Director will round the Maintenance Director prior to the compliance date to ensure that flexible cords (extension cords) were not to be used as a substitute for fixed wiring. The Executive Director will review the preventative maintenance checks performed by the Maintenance Director monthly and sign off that checks have been completed. **By what date the systemic changes will be completed: 1/16/25.**	
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 trans-filling rooms were separated from other areas in the facility in a room that is protected with a one-hour fire-resistive construction in accordance with 2012 NFPA 99 11.5.2.3.1(1). This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director on 12/16/24 at 12:35 p.m., the oxygen trans-filling room door fire protection rating could not be determined due to the fire rating label on the door was covered with paint. Based on an interview at the time of observation, the	K 0927	**K927-Gas Equipment-Transfilling Cylinders** **What corrective action(s)will be accomplished for those residents found to have been affected by the deficient practice:** The trans oxygen filling room label has been restored, showing the 1-hour fire rating **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All fire doors have been inspected to ensure the fire rating label is	01/16/2025

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	Maintenance Director agreed the fire protection rating label on the door was covered in paint and the rating of the door could not be determined. This finding was reviewed with the Administrator and the Maintenance Director during the exit and the conference. 3.1-19(b)		able to be read. **What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur:** The Maintenance Director was educated on the proper maintenance of Fire protection labels for all doors. The QAPI and PM monthly calendar was updated for the Maintenance Director to review fire labels for fire doors to ensure they can be read. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** The Executive Director will round the Maintenance Director prior to the compliance date to ensure all fire door rating labels are able to be read. The Executive Director will review the preventative maintenance checks performed by the Maintenance Director monthly and sign off that checks have been completed. **By what date the systemic changes will be completed: 1/16/25.**	