STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055084	A. BUILDING **02** B. WING _____	**03/18/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBANK POST-ACUTE	**2649 TOPEKA STREET** **RIVERBANK, CA 95367**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	Initial Comments The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. The facility is not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census = 92	E 000	F000 Preparation and/or execution of this Plan of Correction, inclusive of pages 1 through 73, does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by provisions of 42 CFR 483, et seq., and Health and Safety Code Section 1280. In response to the Department's findings we submit the following Plan of Correction which shall constitute Riverbank Post Acute's credible allegation of compliance.	
E 004 SS=E	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:	E 004	**E 004 Develop EP Plan, Review, and Update Annually** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** • The facility initiated a review and update of the Emergency Preparedness Plan (EPP) upon identification of the deficiency. The facility's leadership and emergency preparedness team have reviewed the updated plan on 4/9/25. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** • All residents have the potential to be affected.	

RECEIVED
By MMonterr at 2:37 pm, Apr 25, 2025

Matthew Dahl Administrator 4/25/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

4/28/25 POC approved by Beverly Ong Sladek, SSM-I

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E 004	Continued From page 1 * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to maintain the Emergency Preparedness Plan (EPP). This was evidenced by the failure to maintain and update the EPP. This could result in a delay in protecting the health and safety of 92 of 92 residents. Findings: During document review and interview with staff on 3/18/25, the EPP was reviewed. At 2:45 p.m., there were no documents provided to indicate that the EPP had been updated and reviewed at least annually. The date of the last	E 004	● The facility will update the EPP to ensure all protocols for the protection of all residents during emergencies. A facility-wide audit will be conducted on 4/10/25 to verify that all emergency preparedness procedures and documentation are up to date. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** ● The facility has established a process to review and update the EPP annually. The policy now requires the administrator or designee to document the annual review in a designated log. ● A calendar reminder has been set for December 1st of each year to ensure timely review and update of the EPP by the new year. ● The facility's emergency preparedness committee will convene quarterly to review emergency protocols and make any necessary revisions. ● Maintenance director was retrained on the importance of maintaining an updated EPP, by the Administrator on 4/9/25. **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness.The POC is integrated into the quality assurance system;**	

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E 004	Continued From page 2 EPP review was unknown. During a concurrent interview, Staff 1 stated that the facility had not yet updated the EPP.	E 004	● The EVS Director or designee will conduct quarterly audits of the EPP to ensure it remains updated. The results of these audits will be reported during the facility's Quality Assurance and Performance Improvement (QAPI) meetings. ● Any deficiencies identified during audits will be addressed immediately, and corrective actions will be documented. Date of Compliance 4/18/25	
E 013 SS=E	Development of EP Policies and Procedures CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness	E 013	**E 013: Development of EP Policies and Procedures** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ● The facility initiated a review and update of the Emergency Preparedness (EP) Policies and Procedures upon identification of the deficiency. The facility's leadership and emergency preparedness team have reviewed the updated plan on 4/9/25. **How the facility will identify other residents having the potential to be affected** **by the same deficient practice and what corrective action will be taken;** ● All residents have the potential to be affected.	

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E 013	Continued From page 3 policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to maintain the Emergency Preparedness Plan (EPP). This was evidenced by the failure to maintain and update the Emergency Preparedness (EP) Policies and Procedures. This could result in a delay in protecting the health and safety of 92 of 92 residents. Findings:	E 013	• The facility will update the Emergency Preparedness (EP) Policies and Procedures to ensure all protocols for the protection of all residents during emergencies. An audit will be conducted on 4/10/25 to verify that all Emergency Preparedness (EP) Policies and Procedures are up to date. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** • The facility has established a process to review and update the Emergency Preparedness (EP) Policies and Procedures annually. The policy now requires the administrator or designee to document the annual review in a designated log. • A calendar reminder has been set for December 1st of each year to ensure timely review and update of the Emergency Preparedness (EP) Policies and Procedures by the new year. • The facility's emergency preparedness committee will convene quarterly to review emergency protocols and make any necessary revisions. • The EVS Director was retrained on the importance of maintaining an updated Emergency Preparedness (EP) Policies and Procedures , by the Administrator on 4/9/25.	

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E 013	Continued From page 4 During document review and interview with staff on 3/18/25, the EPP was reviewed. At 2:46 p.m., there were no documents provided to indicate that the EP policies and procedure had been updated and reviewed at least annually. The date of the last EP policy and procedures review was unknown. During a concurrent interview, Staff 1 stated that the facility had not yet updated the EPP policies and procedures.	E 013	**How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness.The POC is integrated into the quality assurance system;** ● The EVS Director or designee will conduct quarterly audits of the Emergency Preparedness (EP) Policies and Procedures to ensure it remains updated. The results of these audits will be reported during the facility's Quality Assurance and Performance Improvement (QAPI) meetings. ● Any deficiencies identified during audits will be addressed immediately, and corrective actions will be documented. Date of Compliance 4/18/25	
E 029 SS=E	Development of Communication Plan CFR(s): 483.73(c) §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.542(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to maintain the Emergency Preparedness Plan (EPP). This was evidenced by the failure to maintain and update the Communication Plan. This could result in a delay in protecting the health and safety of 92 of 92 residents. Findings:	E 029	**E 029: Development of Communication Plan** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ● The facility initiated a review and update of the Communication Plan upon identification of the deficiency. The facility's leadership and emergency preparedness team have reviewed the updated plan on 4/9/25.	

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E 029	Continued From page 5 During document review and interview with staff on 3/18/25, the EPP was reviewed. At 2:47 p.m., there were no documents provided to indicate that the EPP's Communication Plan had been updated and reviewed at least annually. The date of the last Communication Plan review date was unknown. During a concurrent interview, Staff 1 stated that the facility had not yet updated the EPP's Communication Plan. EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.	E 029	**How the facility will identify other residents having the potential to be affected** **by the same deficient practice and what corrective action will be taken;** ● All residents have the potential to be affected. ● The facility will update the Communication Plan to ensure all protocols for the protection of all residents during emergencies. An audit will be conducted on 4/10/25 to verify that the Communication Plan is up to date. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** ● The facility has established a process to review and update the Communication Plan annually. The policy now requires the administrator or designee to document the annual review in a designated log. ● A calendar reminder has been set for December 1st of each year to ensure timely review and update of the Communication Plan by the new year. ● The facility's emergency preparedness committee will convene quarterly to review the Communication Plan and make any necessary revisions. ● The EVS Director was retrained on the importance of maintaining an updated Communication Plan, by the Administrator on 4/9/25.	
E 036 SS=E		E 036		

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E 036	Continued From page 6 *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.	E 036	**How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness.The POC is integrated into the quality assurance system;** ● The EVS Director or designee will conduct quarterly audits of the Communication Plan to ensure it remains updated. The results of these audits will be reported during the facility's Quality Assurance and Performance Improvement (QAPI) meetings. ● Any deficiencies identified during audits will be addressed immediately, and corrective actions will be documented. Date of Compliance 4/18/25 **E 036: EP Training and Testing** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ● The facility initiated a review and update of the Training and Testing Plan upon identification of the deficiency. The facility's leadership and emergency preparedness team have reviewed the updated plan on 4/9/25. ● The testing was conducted on 4/10/25 by the EVS Director ● A training was done on 4/10/25 by the EVS Director	

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E 036	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to maintain the Emergency Preparedness Plan (EPP). This was evidenced by the failure to review and update the Emergency Preparedness (EP) training. This could result in a delay in protecting the health and safety of 92 of 92 residents. Findings: During document review and interview with staff on 3/18/25, the EPP training was reviewed. At 2:48 p.m., there were no documents provided to indicate that the EP training and testing program for new and existing staff had been updated at least annually. The date of the last training and testing review was unknown.	E 036	**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ● All residents have the potential to be affected. ● The facility will update the Training and Testing Plan to ensure all protocols for the protection of all residents during emergencies. An audit will be conducted on 4/10/25 to verify that the Training and Testing Plan is up to date. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** ● The facility has established a process to review and update the Training and Testing Plan annually. The policy now requires the administrator or designee to document the annual review in a designated log. ● An emergency plan test will be conducted twice a year by the EVS Director. ● A training will be done once a year by the EVS Director. ● A calendar reminder has been set for December 1st of each year to ensure timely review and update of the Training and Testing Plan by the new year. ● The facility's emergency preparedness committee will convene quarterly to review the Training and Testing Plan and make any necessary revisions.	
K 000	During a concurrent interview, Staff 1 stated that the facility had not yet updated the EP's training and testing. INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 1963 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY WITH PARTIAL BASEMENT, CONSTRUCTION TYPE V, FULLY SPRINKLERED. Resident Certified Beds: 99 Resident Census: 92 The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The	K 000		

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K 000	Continued From page 8 findings are in accordance with 42 Code of Federal Regulations (CFR) §483.90(a)(b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition.	K 000	● The EVS Director was retrained on the importance of maintaining an updated Training and Testing Plan, by the Administrator on 4/9/25. **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness.The POC is integrated into the quality assurance system;** ● The EVS Director or designee will conduct quarterly audits of the Training and Testing Plan to ensure it remains updated. The results of these audits will be reported during the facility's Quality Assurance and Performance Improvement (QAPI) meetings. ● Any deficiencies identified during audits will be addressed immediately, and corrective actions will be documented. Date of Compliance 4/18/25 **Tag K 161: Building Construction Type and Height** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ● The EVS Director fixed the identified penetration on 4/9/25. ● Maintenance staff have been retrained on monitoring and promptly repairing any penetrations in fire-rated walls.	
K 161 SS=D	The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities. Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered	K 161		

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K 161	Continued From page 9 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the integrity of the building construction. This was evidenced by a penetration in the wall. This could increase smoke spread in the event of a fire. This affected 27 of 92 residents and one of six smoke compartments. Findings: During a tour of the facility and interview with the staff on 3/18/25, the building construction was observed. At 10:11 a.m., a penetration was observed on the east wall by the main entrance to the Kitchen. The wall penetration measured approximately an inch and a half in diameter. The penetration was observed approximately 18 inches from the ceiling. During a concurrent interview, Staff 1 stated that the	K 161	**How the facility will identify other residents having the potential to be affected** **by the same deficient practice and what corrective action will be taken;** ● No additional residents have the potential to be affected. This penetration affected one smoke compartment which contains no resident space. ● A facility-wide inspection was conducted to identify and seal any additional penetrations in fire-rated walls. No other unsealed penetrations were found. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** ● A quarterly wall inspection program has been implemented. ● Maintenance staff were trained on 4/9/25 by the administrator on fire-rated wall requirements and the importance of preserving wall integrity. ● Any new penetrations discovered will be fixed immediately **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction** **is achieved and sustained. This plan must be implemented, and the**	
K 293 SS=D	penetration was likely created by the self-closing mechanism of the Kitchen door colliding into the wall. Exit Signage	K 293	**corrective action evaluated for its effectiveness.The POC is integrated into the quality assurance system;**	

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K 293	Continued From page 10 CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the facility's emergency exit signage. This was evidenced by exit signs that failed to remain illuminated. This could result in a delay in egress in the event of an emergency evacuation. This affected 27 of 92 residents and one of six smoke compartments. Findings: During a tour of the facility and interview with the staff on 3/18/25, the emergency exit signs were observed. 1. At 9:42 a.m., the battery-backup emergency exit sign above the southeast fire doors by Nurse Station A was observed. The exit sign failed to remain illuminated when tested. During a concurrent interview, Staff 1 confirmed the finding and stated he was not aware of the condition of the exit sign. 2. At 10 a.m., the battery-backup emergency exit sign above the northwest wall of the corridor by Nurse Station A was observed. The exit sign failed to remain illuminated when tested. During a	K 293	• The EVS Director or designee will conduct quarterly fire barrier inspections, with results reviewed in QAPI meetings. • Any deficiencies identified will be corrected immediately and documented. Date of Compliance 4/18/25 **Tag K 293: Exit Signage** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** • The facility replaced the batteries in the emergency exit signs above the southeast fire doors and the northwest wall of the corridor by Nurse Station A on 4/21/25. • The signs are now fully operational and compliant with NFPA 101 requirements. **How the facility will identify other residents having the potential to be affected** **by the same deficient practice and what corrective action will be taken;** • A facility-wide audit was conducted to check all emergency exit signs. No additional faulty signs were identified. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;**	

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K 293 K 321 SS=D	Continued From page 11 concurrent interview, Staff 1 confirmed the finding and stated the exit sign required a new battery. Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the hazardous area enclosures.	K 293 K 321	• A monthly inspection of all emergency exit signage has been implemented. • Maintenance staff was trained on 4/9/25 by the Administrator on emergency lighting requirements and proper testing procedures. **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness.The POC is integrated into the quality assurance system;** • The Maintenance Director or designee will conduct monthly tests of all exit signage and document findings. • Any malfunctioning exit signs will be immediately repaired or replaced. • The results of inspections will be reviewed in QAPI meetings to ensure ongoing compliance. Date of Compliance 4/18/25 **Tag K 321: Hazardous Areas - Enclosure** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** • The wheeled shower bed and soiled linen containers obstructing the Shower Room door by Room 22 have been removed. • A self-closing mechanism was purchased on 3/28/25. • The self-closing mechanism will be installed on the door by 4/11/25 to ensure compliance with fire safety regulations.	

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K 321	Continued From page 12 This was evidenced by an obstructed door to a hazardous area and a missing self-closing mechanism. This could result in the passage of a smoke and fire in the event of a fire originating from a hazardous area. This affected 27 of 92 residents and one of six smoke compartments. Findings: During a tour of the facility and interview with the staff on 3/18/25, the facility's hazardous area enclosures were observed. 1. At 10:22 a.m., the corridor door to the Shower Room by Room 22 was observed being obstructed from closure by a wheeled shower bed and three soiled linen containers. The Shower Room was observed storing two yellow and a blue soiled-linen containers. The soiled-linen containers each measured approximately 40 gallons in volume. During a concurrent interview, Staff 1 confirmed the finding and stated that the soiled linen containers were normally stored in the Shower Room observed. 2. At 10:24 a.m., the corridor door to the Shower Room by Room 22 was observed without a self-closing mechanism. The Shower Room measured approximately 60 square feet and was observed storing three soiled-linen containers. The soiled-linen containers each measured approximately 40 gallons in volume. During a concurrent interview, Staff 1 confirmed the finding and stated that he was not aware the door would require a self-closing mechanism. Cooking Facilities CFR(s): NFPA 101	K 321	● On 4/9/25 Housekeeping and maintenance staff were trained by the Administrator on hazardous area storage regulations. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ● A facility-wide inspection was conducted by the EVS Director to ensure all hazardous area doors are unobstructed and self-closing where required. ● No other issues were identified. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** ● A monthly inspection schedule has been established to verify compliance with hazardous area enclosure requirements. ● The inspection will be done by the EVS director **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness.The POC is integrated into the quality assurance system;** ● The EVS Director or designee will perform monthly inspections of hazardous area enclosures.	
K 324 SS=D		K 324		

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K 324	Continued From page 13 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to maintain the cooking facilities. This was evidenced by the failure to provide complete records of the Kitchen's hood fire suppression system. This could cause the Kitchen's fire suppression system to malfunction. This affected the nutritional services available to the residents and one of six smoke compartments. NFPA 101, Life Safety Code, 2012 Edition	K 324	• Any deficiencies will be corrected immediately and documented. • Findings from inspections will be reviewed in QAPI meetings to ensure continued compliance. Date of Compliance 4/18/25 **K 324 – Cooking Facilities** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** • The facility has immediately scheduled a semi-annual inspection of the kitchen's hood fire suppression system to ensure compliance with NFPA 96. • The inspection is scheduled to be completed by the end of April. **How the facility will identify other residents having the potential to be affected** **by the same deficient practice and what corrective action will be taken;** • All residents have the potentially to be affected. • The facility has immediately scheduled a semi-annual inspection of the kitchen's hood fire suppression system to ensure compliance with NFPA 96. • The inspection is scheduled to be completed by the end of April. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** • The EVS Director will conduct a quarterly audit to ensure all fire suppression system maintenance occurs at the required intervals.	

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K 324	Continued From page 14 19.3.2.5.1 Cooking facilities shall be protected in accordance with 9.2.3, unless otherwise permitted by 19.3.2.5.2, 19.3.2.5.3, or 19.3.2.5.4. 9.2.3 Commercial Cooking Equipment. Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition 11.2 Inspection, Testing, and Maintenance of Fire-Extinguishing Systems. 11.2.1* Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at least every 6 months. 11.5 Inspection, Testing, and Maintenance of Listed Hoods Containing Mechanical, Water Spray, or Ultraviolet Devices. Listed hoods containing mechanical or fire-actuated dampers, internal washing components, or other mechanically operated devices shall be inspected and tested by properly trained, qualified, and certified persons every 6 months or at frequencies recommended by the manufacturer in accordance with their listings. Findings: During document review and interview with staff	K 324	• The EVS Director was trained by the Administrator on the importance of safety documentation and maintaining and verifying inspection records. **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness.The POC is integrated into the quality assurance system;** • The EVS Director will conduct a quarterly audit to ensure all fire suppression system maintenance occurs at the required intervals. • Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) committee by the EVS Director for continued oversight. Date of Compliance 4/18/25	

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K 324	Continued From page 15 on 3/18/25, the Kitchen's suppression maintenance records were requested and reviewed. At 10:03 a.m., the facility failed to provide one of two semi-annual inspection records for the Kitchen's hood fire suppression system. The date of the last suppression system service was 11/13/24. During a concurrent interview, Staff 1 confirmed the finding and stated that he would not have access to the maintenance record since it had been conducted before he had worked at the facility. Staff 1 stated he was unsure when the service had been conducted. This was a repeated deficiency from the recertification survey dated 9/27/23.	K 324		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to maintain the Fire Alarm System (FAS). This was evidenced by trouble signals on the Fire Alarm Control Panel (FACP) and by the failure to conduct FACP battery testing. This could result in a failure to activate the Fire Alarm System in the event of a	K 345	**K 345 – Fire Alarm System Testing and Maintenance** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ● The facility immediately contacted its fire alarm system vendor to diagnose and address the ongoing trouble signals. The vendor completed necessary repairs on 4/4/25, and all alarms are now fully operational. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ● All residents have the potential to be affected. ● On 4/4/25 The facility performed a comprehensive assessment of all fire alarm system components to identify any additional deficiencies. No other deficiencies were noted.	

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K 345	Continued From page 16 fire. This affected 92 of 92 residents and six of six smoke compartments. NFPA 101, Life Safety Code, 2012 Edition 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 9.6.1.5* To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. 9.6.2.10.1.1 Where required by another section of this Code, single-station and multiple-station smoke alarms shall be in accordance with NFPA 72, National Fire Alarm and Signaling Code, unless otherwise provided in 9.6.2.10.1.2, 9.6.2.10.1.3, or 9.6.2.10.1.4. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition 10.14.3 Coded Supervisory Signal. 10.14.3.1 A coded supervisory signal shall be permitted to consist of two rounds of the number transmitted to indicate a supervisory off-normal condition. 10.14.3.2 A coded supervisory signal shall be permitted to consist of one round of the number transmitted to indicate the restoration of the supervisory condition to normal. 14.3.1 * Unless otherwise permitted by 14.3.2 visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction. 1. Control equipment: fire alarm systems	K 345	**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** ● The EVS Director will perform a monthly check for 3 months then semi-annually to ensure semi-annual and annual fire alarm testing is completed on time. ● The EVS Director was trained by the Administrator on 4/9/25 on the important of fire alarm testing and functionality. **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness.The POC is integrated into the quality assurance system;** ● The EVS Director will perform a monthly check for 3 months then semi-annually to ensure semi-annual and annual fire alarm testing is completed on time. ● Results will be reviewed in the QAPI meetings for ongoing compliance oversight. Date of Compliance 4/18/25	

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K 345	Continued From page 17 monitored for alarm, supervisory, and trouble signals (a) Fuses - Initial/Reacceptance; Annually (b) Interfaced equipment - Initial/Reacceptance; Annually (c) Lamps and LEDs - Initial/Reacceptance; Annually (d) Primary (main) power supply - Initial/Reacceptance; Annually 14.4.5* Testing Frequency. Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. Table 14.4.5 Testing Frequencies 6. Batteries-fire alarm systems (d) Sealed lead-acid type (1) Charger test (Replace battery as needed.) - Initial/Reacceptance; Annually (2) Discharge test (30 minutes) - Initial/Reacceptance; Annually (3) Load voltage test - Initial/Reacceptance; Semiannually Findings: During a tour of the facility, document review and interview with staff on 3/18/25, the FACP was observed, and the FAS testing records were requested. 1. At 9:30 a.m., the FACP in Nurse Station A was observed with a display showing a trouble signal for "Room #23 Smoke". During a concurrent interview, Staff 1 stated that it was the first time he had noticed the trouble signal on the FACP. Staff 1 stated that the trouble signal likely originated from a smoke detector that had been accidentally hit by a vital machine in Room 23.	K 345		

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K 345	Continued From page 18 Staff 1 reset the FACP upon noticing the trouble signal. After the reset, the FACP began to display a cycle of trouble signals for devices throughout the facility. A different trouble signal was displayed on the FACP approximately every two seconds. A monitoring report dated 3/18/25 showed the cycle of trouble signals that changed approximately every two seconds. Staff 1 spoke with the FAS vendor who stated that a technician would be required on-site to diagnose the issue. At 11:10 a.m., the water flow device, two smoke detectors, and a tamper switch were tested. All the according notification devices activated, and the testing signals were received by the monitoring company. 2. At 1:45 p.m., the facility failed to conduct the annual discharge test for the FACP batteries. The date of the last discharge test was unknown. During a concurrent interview, Staff 1 confirmed the finding and stated that the facility would inquire about battery testing with their vendor. The facility was given until 9 a.m. on 3/19/25 to submit the according testing records. No battery testing records were received. 3. At 1:46 p.m., the facility failed to conduct the annual charger test for the FACP batteries. The date of the last charger test was unknown. During a concurrent interview, Staff 1 confirmed the finding and stated that the facility would inquire about battery testing with their vendor. The facility was given until 9 a.m. on 3/19/25 to submit the according testing records. No battery testing records were received.	K 345		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353	**K 353 – Sprinkler System Maintenance and Testing** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ● The facility has immediately removed Dust and debris on the exterior sprinklers. ● The required signage for the fire department connection and control valve were installed on 4/2/25 by the EVS Director.	

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K 353	Continued From page 19 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to maintain the automatic sprinkler system. This was evidenced by debris on sprinkler components, a failed sprinkler testing record, and, by missing signage to the fire department connection (FDC) and control valve. This could result in a malfunction to the automatic sprinkler system in the event of a fire. This affected 92 of 92 residents and six of six smoke compartments. NFPA 101, Life Safety Code, 2012 Edition 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5.	K 353	**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ● All residents have the potential to be affected. ● A full facility-wide sprinkler system inspection has been conducted to identify any additional deficiencies. No other deficiencies have been identified. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** ● A monthly maintenance checklist will be completed by the EVS Director to ensure that all sprinkler system components are clean and free of debris. **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness.The POC is integrated into the quality assurance system;** ● A monthly maintenance checklist will be completed by the EVS Director to ensure that all sprinkler system components are clean and free of debris. ● Results will be reviewed in the QAPI meetings for ongoing compliance oversight. Date of Compliance 4/18/25	

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K 353	Continued From page 20 9.7.1 Automatic Sprinklers. 9.7.1.1 * Each automatic sprinkler system required by another section of this Code shall be in accordance with one of the following: (1) NFPA 13, Standard for the Installation of Sprinkler Systems 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 13, Standard for the Installation of Sprinkler System, 2010 Edition 7.7.1.5.1 Caution signs shall be attached to all valves controlling sprinklers. 7.7.1.5.2 The caution sign shall be worded as follows: This valve controls fire protection equipment. Do not close until after fire has been extinguished. Use auxiliary valves when necessary to shut off supply to auxiliary equipment. CAUTION: Automatic alarm may be sounded if this valve is closed. 8.17.2.4.5 Where a fire department connection services only a portion of a building, a sign shall be attached indicating the portions of the building served 8.17.2.4.7 Signs. 8.17.2.4.7.1 Each fire department connection to sprinkler systems shall be designated by a sign having raised or engraved letters at least 1 in. (25.4 mm) in height on plate or fitting reading service design - for example, AUTOSPKR., OPEN SPKR., AND STANDPIPE. 8.17.2.4.7.2 A sign shall also indicate the pressure required at the inlets to deliver the greatest system demand.	K 353		

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K 353	Continued From page 21 NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition 5.2.1.1.1 * Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5) *Loading (6) Painting unless painted by the sprinkler manufacturer Findings: During a tour of the facility, document review and interview with staff on 3/18/25, the sprinkler system components were observed and the sprinkler system testing records were requested and reviewed. 1. At 11:05 a.m., two of two sprinklers protecting the outside of the front entrance of the facility was observed with dust debris along the body and deflector. During a concurrent interview, Staff 1 confirmed the finding and stated that the sprinkler components were usually cleaned on a monthly basis. 2. At 1:13 p.m., the annual sprinkler testing record date 2/4/25 displayed a failed test. The	K 353		

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K 353	Continued From page 22 annual record showed a failed test due to missing signage for the control valves and fire department connection servicing the building. During a concurrent interview, Staff 1 confirmed the finding and stated that the facility was in the process of obtaining new signs. 3. At 2 p.m., the FDC on the riser along the southwest side of the building by the entrance was observed. The FDC was observed missing identification signage. During a concurrent interview, Staff 1 confirmed the finding and stated that the facility was in the process of obtaining new signs. 4. At 2:02 p.m., the control valve on the riser along the southwest side of the building by the entrance was observed. The control valve was observed missing identification signage. During a concurrent interview, Staff 1 confirmed the finding and stated that the facility was in the process of obtaining new signs.	K 353		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that	K 363	**K 363 - Corridor Doors** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ● Maintenance staff lubricated and adjusted the self-closing mechanisms on the Shower Room door by Room 6 and the Salon door by Room 13 to ensure proper latching. ● The EVS Director replaced both door handles on 4/10/25 to ensure proper latching. ● Both doors were tested three times and successfully latched upon closure. **How the facility will identify other residents having the potential to be affected** **by the same deficient practice and what corrective action will be taken;**	

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K 363	Continued From page 23 do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by non-latching corridor doors. This can increase the passage of smoke through smoke compartments. This affected 34 of 92 residents and two of six smoke compartments. Findings: During a tour of the facility and interview with the staff on 3/18/25, the corridor doors were observed.	K 363	• No additional residents have the potential to be affected. This latching concern only affects the two smoke compartments and cannot affect the other smoke compartments. • On 4/10/25 a facility-wide inspection was conducted to identify any other door latching issues. No other issues were found. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** • On 4/10/25 a facility-wide inspection was conducted to identify any other door latching issues. No other issues were found. • The maintenance team has implemented a monthly inspection schedule to ensure all corridor doors latch properly and self-closing mechanisms function as required. • The EVS Director was trained by the Administrator on the importance of proper door maintenance, including lubrication, alignment, and troubleshooting air pressure issues that may affect door closure. **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness.The POC is integrated into the quality assurance system;**	

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K 363	Continued From page 24 1. At 9:52 a.m., the corridor door to the Shower Room by Room 6 was observed with a self-closing mechanism. The corridor door failed to latch when tested for closure. The door was tested approximately three times. During a concurrent interview, Staff 1 stated that the corridor door likely needed lubricant in order for it to fully close. 2. At 10:43 a.m., the corridor door to the Salon by Room 13 was observed with a self-closing mechanism. The corridor door failed to latch when tested for closure. The door was tested approximately three times. During a concurrent interview, Staff 1 stated that the air pressure in the room likely prevented the door from full closure.	K 363	● The maintenance team has implemented a monthly inspection schedule to ensure all corridor doors latch properly and self-closing mechanisms function as required. ● Results will be reviewed in the QAPI meetings for ongoing compliance oversight. Date of Compliance 4/18/25	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the smoke integrity of the	K 372	**K 372 - Smoke Barrier Construction** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ● The identified penetration was sealed using fire-rated caulking and fire-resistant materials in accordance with NFPA 101 and NFPA 8.5.6.2 standards. **How the facility will identify other residents having the potential to be affected** **by the same deficient practice and what corrective action will be taken;** ● No other residents have the potential to be affected. The penetration was limited to its specified smoke compartment. ● A comprehensive review of all smoke barrier walls was conducted to identify any other unsealed penetrations. No other issues were found	

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K 372	Continued From page 25 smoke barrier walls. This was evidenced by an unsealed penetration in the smoke barrier wall. This could result in the spread of smoke in the event of a fire. This affected 27 of 92 residents and one of six smoke compartments. NAPA 101, Life Safety Code, 2012 Edition 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1/2-hour fire resistance rating, unless otherwise permitted by one of the following: (1) This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply: (a) Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(ac). (B) Not less than two separate smoke compartments shall be provided on each floor. (2) Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air-conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 has been provided for smoke compartments adjacent to the smoke barrier. 8.5.6.2 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 transfer of smoke. 8.5.6.3 Where a smoke barrier is also constructed as a fire barrier, the penetrations	K 372	**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** ● A quarterly smoke barrier inspection protocol has been implemented, with documentation maintained for compliance review. ● The EVS Director was trained by the administrator on the importance of proper inspection and sealing of smoke barrier penetrations. **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness.The POC is integrated into the quality assurance system;** ● A quarterly smoke barrier inspection protocol has been implemented, with documentation maintained for compliance review. ● Results will be reviewed in the QAPI meetings for ongoing compliance oversight. Date of Compliance 4/18/25	

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K 372	Continued From page 26 shall be protected in accordance with the requirements of 8.3.5 to limit the spread of fire for a time period equal to the fire resistance rating of the assembly and 8.5.6 to restrict the transfer of smoke, unless the requirements of 8.5.6.4 are met. Findings: During a tour of the facility and interview with the staff on 3/18/25, the smoke barrier walls were observed. At 10:56 a.m., the smoke barrier wall above the fire doors by Room 12 was observed with a penetration. The penetration measured approximately two inches in diameter and contained metal conduit. During a concurrent interview, Staff 1 confirmed the finding and stated he had not yet inspected the condition of the smoke barrier walls.	K 372		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test	K 918	**K 918 - Essential Electrical Systems** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** • Finding 1: On 3/18/25, the current EVS Director performed and documented a visual inspection of the 10kW generator to confirm it is functional. No issues were found. • Finding 2: On 3/20/25, the EVS Director inspected the 25kW generator. No issues were found. • Finding 3: Load test completed on 10kW generator on 3/28/25. • Finding 4: Load test completed on 25kW generator on 3/28/25. • Finding 5: Conductance test completed for 10kW generator on 3/18/25; batteries confirmed to be within operational parameters.	

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K 918	Continued From page 27 under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the Emergency Power Supply System (EPSS). This was evidenced by the failure to conduct the required tests and inspections to the generators. This can result in a malfunctioning emergency generator and loss of emergency power during an extended power outage. This affected 92 of 92 residents and six of six smoke compartments. NFPA 101, Life Safety Code, 2012 Edition 19.5.1.1 Utilities shall comply with the provisions of Section 9.1. 9.1.3 Emergency Generators and Standby Power Systems. Where required for compliance with this Code, emergency generators and standby power systems shall comply with 9.1.3.1 and 9.1.3.2. 9.1.3.1 Emergency generators and standby	K 918	• Finding 6: Conductance test completed for 25kW generator on 3/20/25; batteries confirmed to be within operational parameters. • Finding 7: Facility contracted with vendor to conduct 4-hour load test for the 10kW generator on 1/8/25 • Finding 8: Facility contracted with vendor to conduct 4-hour load test for the 25kW generator on 1/8/25. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** • All Residents have the potential to be affected. • The EVS Director conducted a full generator inspection on 3/18/25 to verify the emergency power system's functionality. No other issues were identified. • The EVS Director conducted an additional inspection 3/27/25 to verify the emergency power system's functionality. No other issues were identified.	

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K 918	Continued From page 28 power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition 8.4 Operational Inspection and Testing. 8.4.9* Level 1 EPSS shall be tested at least once within every 36 months. 8.4.9.5 The minimum load for this test shall be as specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. 8.4.9.6 The test required in 8.4.9 shall be permitted to be combined with one of the monthly tests required by 8.4.2 and one of the annual tests required by 8.4.2.3 as a single test. 8.4.9.7 Where the test required in 8.4.9 is combined with the annual load bank test, the first 3 hours shall be at not less than the minimum loading required by 8.4.9.5 and the remaining hour shall be at not less than 75 percent of the nameplate kW rating of the EPS. Findings: During a tour of the facility, document review, and interview with staff on 3/18/25, inspection and testing records were requested and reviewed. 1. At 1:26 p.m., the facility failed to conduct 10 of 52 weekly generator visual inspections for their 10-kW propane generator. During a concurrent interview, Staff 1 confirmed the finding and stated that he was unsure if the weekly inspections had been conducted since he had not been working at the facility at the time. 2. At 1:27 p.m., the facility failed to conduct 10 of 52 weekly generator visual inspections for their	K 918	**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** ● EVS Director will conduct a weekly non-load test for both the 10kW and 25kW generators. ● EVS Director will conduct a monthly load test for both the 10kW and 25kW generators. ● EVS Director will conduct battery conductance tests on both the 10kW and 25kW generators ● Our vendor will conduct a 4 hour load test for both the 10kW and 25kW generators. ● A new EVS Director has been hired, and we will continue to monitor and support ongoing compliance. ● The EVS Director was trained by the administrator on 3/9/25 on the importance of proper testing, documentation, and reporting of generator inspections and load tests. **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness.The POC is integrated into the quality assurance system;** ● EVS Director will conduct weekly and monthly tests for both the 10kW and 25kWgenerators. ● Results will be reviewed in the QAPI meetings for ongoing compliance oversight. Date of Compliance 4/18/25	

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K 918	Continued From page 29 25-kW propane generator. During a concurrent interview, Staff 1 confirmed the finding and stated that he was unsure if the weekly inspections had been conducted since he had not been working at the facility at the time. 3. At 1:28 p.m., the facility failed to conduct three of 12 monthly load tests for their 10-kW propane generator. The facility was missing testing records for the months of March, April, and September of 2024. During a concurrent interview, Staff 1 confirmed the finding and stated that he was unsure if the monthly load tests had been conducted since he had not been working at the facility at the time. Staff 1 stated he was unsure why the testing record for September 2024 had been missing. 4. At 1:29 p.m., the facility failed to conduct three of 12 monthly load tests for their 25-kW propane generator. The facility was missing testing records for the months of March, April, and September of 2024. During a concurrent interview, Staff 1 confirmed the finding and stated that he was unsure if the monthly load tests had been conducted since he had not been working at the facility at the time. Staff 1 stated he was unsure why the testing record for September 2024 had been missing. 5. At 1:30 p.m., the facility failed to conduct three of 12 monthly conductance tests for their 10-kW propane generator batteries. The facility was missing testing records for the months of March, April, and September of 2024. During a concurrent interview, Staff 1 confirmed the finding and stated that he was unsure if the monthly conductance tests had been conducted since he had not been working at the facility at the time.	K 918		

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K 918	Continued From page 30 Staff 1 stated he was unsure why the battery testing record for September 2024 had been missing. 6. At 1:31 p.m., the facility failed to conduct three of 12 monthly conductance tests for their 25-kW propane generator batteries. The facility was missing testing records for the months of March, April, and September of 2024. During a concurrent interview, Staff 1 confirmed the finding and stated that he was unsure if the monthly conductance tests had been conducted since he had not been working at the facility at the time. Staff 1 stated he was unsure why the battery testing record for September 2024 had been missing. 7. At 1:35 p.m., the facility failed to conduct the four-hour load tests conducted every three years for their 10-kW propane generator. The date of the last 4-hour generator load test was unknown. During a concurrent interview, Staff 1 confirmed the finding and stated that he was unsure if a 4-hour load test had been conducted since he had just started working at the facility. The facility was given until 9 a.m. on 3/19/25 to submit the according generator testing records. No 4-hour testing record was received. 8. At 1:36 p.m., the facility failed to conduct the four-hour load tests conducted every three years for their 25-kW propane generator. The date of the last 4-hour generator load tests was unknown. During a concurrent interview, Staff 1 confirmed the finding and stated that he was unsure if a 4-hour load test had been conducted since he had just started working at the facility. The facility was given until 9 a.m. on 3/19/25 to submit the according generator testing records.	K 918		

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	055084	A. BUILDING **02** B. WING _____	**03/18/2025**

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K 918 K 919 SS=D	Continued From page 31 No 4-hour testing record was received. Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the electrical equipment. This was evidenced by an exposed opening in an electrical panel. This affected 27 of 92 residents and one of six smoke compartments. NFPA 101- Life Safety Code- 2012 Edition 19.5.1.1 Utilities shall comply with the provisions of Section 9.1. 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, National Electrical Code, 2011 Edition 408.7 Unused Openings. Unused openings for circuit breakers and switches shall be closed using identified closures, or other approved means that provide protection substantially equivalent to the wall of the enclosure. Findings:	K 918 K 919	**K 919 Electrical Equipment - Other CFR(s):** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ● The circuit breaker filler plate was ordered on 3/31/25 and is scheduled to arrive 4/10/25 ● The missing cover for the breaker space labeled "24" will be replaced on the arrival of the breaker cover by 4/11/25. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ● EVS director conducted a facility wide inspection on 3/19/25 of all electrical breaker panels to ensure all available spaces are sealed and covered properly. ● Did not find any other open breaker slots. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** ● The facility will conduct quarterly inspections of all electrical panels and wiring to ensure compliance. These inspections will be documented, and corrective actions will be taken as necessary.	

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K 919	Continued From page 32 During a tour of the facility and interview with the staff on 3/18/25, the electrical equipment was observed. At 10:38 a.m., the electrical panel in the Biohazard Storage Room by Room 27 was observed with an exposed opening. One of the 42 breaker spaces were observed missing a cover. The missing cover was observed labeled as "24". During a concurrent interview, Staff 1 confirmed the finding and stated he was unaware of the gap in the electrical panel.	K 919	• The EVS Director was trained by the Administrator on 4/9/25 on the importance of electrical panel Safety. **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness.The POC is integrated into the quality assurance system;** • The EVS Director will conduct quarterly inspections of all electrical panels and wiring to ensure compliance. These inspections will be documented, and corrective actions will be taken as necessary. • Results will be reviewed in the QAPI meetings for ongoing compliance oversight. Date of Compliance 4/18/25	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8	K 920	**K 920 - Electrical Equipment - Power Cords and Extension Cords** **Plan of Correction:** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** • The orange extension cord found in the Human Resources Office was removed on 3/18/25 and replaced with a fixed, properly installed electrical setup.	

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K 920	Continued From page 33 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the electrical equipment. This was evidenced by the use of an extension cord and by a missing receptacle faceplate. This could result in an electrical fire. This affected 52 of 92 residents and two of six smoke compartments. NFPA 101, Life Safety Code, 2012 Edition 19.5.1.1 Utilities shall comply with the provisions of Section 9.1. 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, National Electrical Code, 2011 Edition 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B) (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code (7) Where subject to physical damage 400.10	K 920	• The missing receptacle faceplate in the Director of Staff Development's Office was replaced on 3/18/25, ensuring that it fully covers the opening and is seated correctly against the mounting surface. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** • The EVS Director conducted a facility wide inspection of resident rooms and offices on 3/19/25 to ensure there's no other improper use of extension cords. • No other issues were identified. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** • A monthly inspection will be conducted by the EVS Director or designee to ensure that all receptacles are covered with faceplates and that no extension cords are used improperly. • The EVS Director was trained by the Administrator on 4/9/25 on the importance of faceplates and avoidance of improper extension cables. • The Human Resource Director was 3/18/25 trained by the EVS Director.	

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K 920	Continued From page 34 Pull at Joints and Terminals. Flexible cords and cables shall be connected to devices and to fittings so that tension is not transmitted to joints or terminals. Exception: Listed portable single-pole devices that are intended to accommodate such tension at their terminals shall be permitted to be used with single-conductor flexible cable. 400.10 Pull at Joints and Terminals. Flexible cords and cables shall be connected to devices and to fittings so that tension is not transmitted to joints or terminals. 406.6 Receptacle Faceplates (Cover Plates). Receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. Receptacle faceplates mounted inside a box having a recess-mounted receptacle shall effectively close the opening and seat against the mounting surface. Findings: During a tour of the facility and interview with the staff on 3/18/25, the electrical equipment was observed. 1. At 9:48 a.m., an orange extension cord was observed along the northeast wall of the Human Resources Office. The extension cord was observed on top of wall cabinets and powering fan components. During a concurrent interview, Staff 1 confirmed the finding and stated he was unsure how long the extension cord had been in use. 2. At 10:26 a.m., the receptacle along the west wall of the Director of Staff Development's Office was observed missing a faceplate. During a	K 920	**How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness.The POC is integrated into the quality assurance system;** ● A monthly inspection will be conducted by the EVS Director or designee to ensure that all receptacles are covered with faceplates and that no extension cords are used improperly. ● Results will be reviewed in the QAPI meetings for ongoing compliance oversight.	

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K 920	Continued From page 35 concurrent interview, Staff 1 confirmed the finding and stated that faceplate was likely removed from the receptacle on accident.	K 920		