STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504011	A. BUILDING _____ B. WING _____	**4/15/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOREPOINTE NURSING CENTER	**26001 EAST JEFFERSON AVENUE SAINT CLAIR SHORES, MI 48081**

(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
E0000 SS=	Initial Comments On April 14 - 15, 2025, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Shorepointe Nursing Center - St Clair Shores was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		
K0000 SS=	INITIAL COMMENTS On April 14 - 15, 2025, a Life Safety Recertification Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Shorepointe Nursing Center - St Clair Shores was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 482.90(a), Life Safety from Fire and the applicable provisions of the 2012 Edition of the National Fire Protection Agency (NFPA) 101, Life Safety Code and the 2012 Edition of NFPA 99, Health Care Facilities Code. The facility is a 3 - story building of Type II (222) construction with no basement, built in 1984, and an addition built of the same construction type finished in 2023 . The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 200 certified beds. At the time of the survey the census was 175.	K0000		

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

Electronically Signed | 04/30/2025

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.

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K0222 SS= F	Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-	K0222	K222 Egress Doors 1.The facility failed to ensure doors in a required means of egress are not equipped with a latch or lock that requires the use of a tool or key from the egress unless meeting the special locking arrangements for clinical needs in accordance with 19.2.2.2.5.1 and 19.2.2.2.6. a. Emergency exit to egress door to Stairway “A” 3rd floor was assessed and serviced. b. Emergency exit egress door on 3rd floor by sitting was assessed and serviced. c. Emergency exit egress door to stairway “A” 2nd floor was assessed and serviced. 2.The maintenance director and staff will be educated on checking and maintaining any breaches in egress doors with a latch or lock throughout the facility. 3.To ensure continued compliance is maintained with the emergency fire exits, the Maintenance Director/designee will complete random audits 5x a week for 4 weeks. Findings will be reported to the QAPI committee. 4.The facility Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 5/13/2025 and for sustained compliance thereafter.	5/13/2025

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	CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure doors in a required means of egress are not equipped with a latch or lock that requires the use of a tool or key from the egress side unless meeting the special locking arrangements for clinical needs in accordance with 19.2.2.2.5.1 and 19.2.2.2.6. This deficient practice could affect all 175 facility residents in the event of a fire and/or other emergency evacuation situation. Findings Include: 1) On April 14, 2025 at 2:14 PM, observation revealed the emergency exit egress door to stairway "A", 3rd floor is signed as a 15-second delay with alarm to sound upon opening to exit. However, when tested the door freely opened without any resistance or alarm activation. 2) On April 14, 2025 at 2:26 PM, observation revealed the emergency exit egress door 3rd floor stairway by the Sitting Room is signed as a 15-second delay with alarm to sound			

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	upon opening to exit. However, when tested the door freely opened without any resistance or alarm activation. 3) On April 14, 2025 at 2:41 PM, observation revealed the emergency exit egress door to stairway "A", 2nd floor is signed as a 15-second delay with alarm to sound upon opening to exit. However, when tested the door freely opened without any resistance or alarm activation. These deficiencies could potentially allow resident(s) to exit the controlled space and progress into the stairway prior to being detected by staff and possibly lead in injury, elopement and/or confusion for those exiting in an emergency. These findings were confirmed with the facility Maintenance Director at the time of observation.			

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K0225 SS= E	Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure stairways and smokeproof enclosures used as exits are in accordance with 7.2, as required by 19.2.2.3 and 19.2.2.4.7.2. This deficient practice could affect 58 of 175 facility residents in the vent of a fire situation. Findings Include: On April 14, 2025 at 10:11 AM, observation revealed the electronic stairway path interrupter installed on the 2nd floor stairway path of egress by the elevators was inoperative. This could lead to occupants evacuating to the lower level of the facility and miss the proper egress level during a fire or other emergency event with diminished visibility. These findings were confirmed with the facility Maintenance Director at the time of observation.	K0225	K225- Stairways and Smoke Proof Enclosures 1.The facility has failed to ensure stairways and smokeproof enclosures used as exits are in accordance with 7.2, as required by 19.2.2.3 and 19.2.2.4.7.2. a. The electronic stairway path interrupter installed on the 2nd floor stairway path of egress by the elevators is operative. 2.The maintenance director and staff will be educated on the importance of egress doors/gates are continuously activated and working properly. 3.To ensure continued compliance is maintained with the stairway path interrupter, the Maintenance Director/Designee will complete random audits 5x a week for 4 weeks. Findings will be reported to the QAPI committee. 4.The facility Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 5/13/2025 and for sustained compliance thereafter.	5/13/2025
K0293 SS= F	Exit Signage 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.)	K0293	K293- Exit Sign 1.The Facility failed to ensure exit and directional signs are displayed in accordance with 7.10, continuously illuminated and served by the emergency lighting system as required by 19.2.10.1. a. Ceiling mounted exit sign 3rd floor Lakeland	5/13/2025

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	This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure exit and directional signs are displayed in accordance with 7.10, continuously illuminated and served by the emergency lighting system as required by 19.2.10.1. This deficient practice could affect all 175 facility residents in the event of a fire situation. Findings Include: 1) On April 14, 2025 at 1:27 PM, observation revealed the ceiling mounted exit sign 3rd floor Lakeland Hall by stairway "C" was inoperative. 2) On April 14, 2025 at 1:42 PM, observation revealed the ceiling mounted exit signs 3rd floor in the corridor at Jefferson central stairway door and the remainder of the 3rd floor were inoperative. 3) On April 14, 2025 at 2:36 PM, observation revealed the ceiling mounted exit sign 2nd floor Jefferson Hall was inoperative. These findings were confirmed with the facility Maintenance Director at the time of observation.		Hall by stairway “C” is now operative. b. Ceiling mounted exit signs 3rd floor in the corridor at Jefferson Central Stairway door and the remainder of the 3rd floor are now operative. c. Ceiling mounted exit sign 2nd Floor Jefferson Hall is now operative. 2. The maintenance director and staff will be educated on the importance of exit signs/emergency lighting to be continuously activated and working properly. 3. To ensure continued compliance is maintained with the exit sign lighting/emergency lighting, the Maintenance Director/Designee will complete random audits 5x a week for 4 weeks. Findings will be reported to the QAPI committee. 4. The facility Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 5/13/2025 and for sustained compliance thereafter.	
K0324 SS= F	Cooking Facilities 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	K0324	K324- Cooking Facilities 1.The facility failed to ensure cooking facilities are protected in accordance with NFPA 96. a. The facility conducted a Monthly hood suppression system inspections for the range hood with proper documentation.	5/13/2025

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	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 record review and interview, the facility failed to ensure cooking facilities are protected in accordance with NFPA 96. This deficient practice could affect all 175 facility residents in the event of a fire resulting from an improperly maintained fire suppression system. Findings Include: 1) On April 15, 2025 at 3:27 PM, record review revealed the facility failed to provide evidence of the required Semi-annual Service Dates for the installed range hood suppression system from 2023 to present. The last recorded service date was 2/15/2023. 2) On April 15, 2025 at 3:39 PM, record review revealed the facility failed to provide evidence of the required "Owner's Monthly Hood Suppression System Inspection" for their installed range hood suppression		b. The facility conducted a Semi-Annual Service for the installed rand hood suppression system with proper documentation. 2.The Maintenance Director and Food Service Director were educated on the importance of monthly and semi-annual testing and the proper documentation to maintain compliance. 3.To ensure continued compliance of the Hood Suppression System is maintained the Maintenance Director/Designee will report monthly and semi-annually. Findings will be reported to the QAPI committee. 4.The facility Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 5/13/2025 and for sustained compliance thereafter.	

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	system, from 2024 to present. No compliance supporting documentation was presented to the surveyor by the time of exit. These findings were confirmed with the facility Maintenance Director at the time of record review.			

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K0345 SS= F	Fire Alarm System - Testing and Maintenance 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 and interview, the facility failed to ensure the fire alarm system was tested and maintained in accordance with an approved program complying with NFPA 70 and NFPA 72. This deficient practice could affect all 175 facility residents in the event of a fire situation. Findings Include: On April 14, 2025 at 12:32 PM, observation revealed the fire alarm remote panel in the vestibule to Physical Therapy (new) did not display the correct date and time information. The panel displayed: 0506 on 06/03/2059. These findings were confirmed with the facility Maintenance Director at the time of observation.	K0345	K 345- Fire Alarm System- Maintenance and Testing 1. The facility failed to ensure the fire alarm system was tested and maintained in accordance with an approved program complying with NFPA 70 and NFPA 72. a. The Fire alarm remote panel date and time in the vestibule to Physical Therapy is correct. 2. The Maintenance director and staff will be educated on the importance of rounding and ensuring the time and date on the fire alarm remote panels have the correct date and time. 3. To ensure compliance is maintained, the Maintenance Director/designee will complete a random audit 3x a week for 4 weeks. Findings will be reported to the QAPI committee. 4. The facility Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 5/13/2025 and for sustained compliance thereafter.	5/13/2025
K0353 SS= F	Sprinkler System - Maintenance and Testing 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	K0353	K353 – Sprinkler System Maintenance and Testing 1.The facility failed to provide sprinkler system maintenance and testing as required by NFPA 25.	5/13/2025

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	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, record review and interview, the facility failed to provide sprinkler system maintenance and testing as required by NFPA 25. This deficient practice could affect all 175 facility residents in the event of fire. Findings Include: 1) On April 14, 2025 at 10:08 AM, observation revealed ceiling tile penetration at the conduit and vent duct in the IT/ Telecom Room 2nd floor by the stairs (new side). 2) On April 14, 2025 at 10:18 AM, observation revealed ceiling tile penetration at the water line in the corner of the 2nd floor storage room with the roof access (new side). 3) On April 14, 2025 at 2:49 PM, observation revealed the sprinkler in the 2nd floor Room #235 bathroom is missing the escutcheon ring.		a. The ceiling tile penetration on 2nd floor new side by IT/Telecom room has been replaced. b. The ceiling penetration in 2nd floor storage room with roof access has been replaced. c. Escutcheon plate in the 2nd floor room #235 has been replaced. d. The ceiling tile penetration in Maintenance Office by the IT equipment rack has been replaced. e. Dirty Sprinkler heads behind the dryers have been cleaned. f. Missing Sprinkler head in the Dietary restroom has been replaced. g. Escutcheon Plate in the Dialysis den has been replaced. h. Missing Sprinkler in the 1st floor conference room has been replaced. i. All combustibles and stock items within 18” have been removed from dialysis storage room. j. Missing ceiling tile above the washers in the laundry room has been replaced. 2.The maintenance director and staff will be educated on the importance of routine rounding to ensure the sprinkler heads have escutcheon plates and are clean, ceiling times maintain no breaches, and combustible/stock items maintain 18’ from the ceiling. 3.To ensure continued compliance, the Maintenance director/designee will complete random audits 5x a week for 4 weeks. Findings will be reported to the QAPI committee. 4.The facility Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 5/13/2025 and for sustained compliance thereafter.	

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	4) On April 14, 2025 at 3:20 PM, observation revealed ceiling tile missing in the Maintenance Office above the IT equipment rack. 5) On April 14, 2025 at 3:28 PM, observation revealed dirty sprinkler heads behind the dryers in the laundry. 6) On April 14, 2025 at 3:29 PM, observation revealed a missing ceiling tile above the washers in the laundry. 7) On April 14, 2025 at 3:33 PM, observation revealed sprinkler missing the concealed cover in the Dietary Rest Room. 8) On April 14, 2025 at 4:32 PM, observation revealed sprinkler missing escutcheon plate in the Dialysis Treatment Room. 9) On April 14, 2025 at 4:33 PM, observation revealed sprinkler missing the concealed cover in the 1st floor Conference Room. 10) On April 14, 2025 at 4:40 PM, observation revealed stock items stored within 18" of the sprinkler head in the vestibule for the 1st floor dialysis storage. These findings were confirmed with the facility Maintenance Director at the time of observation. 11) On April 15, 2025 at 3:43 PM, record review revealed the facility failed to provide evidence of the required Quarterly Flow Test for 1st quarter 2025 and 4th quarter 2024, for their installed automatic fire suppression system. No compliance supporting			

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	documentation was presented to the surveyor by the time of exit. These findings were confirmed in interview with the facility Maintenance Director at the time of record review.			
K0355 SS= E	Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure portable fire extinguishers are selected, installed, inspected and maintained in accordance with NFPA 10. This deficient practice could affect 28 of 175 facility residents in the event of a fire situation. Findings Include: On April 14, 2025, at 12:25 PM, observation revealed the fie extinguisher by the counter in the Physical Therapy Charting Room was obstructed by combustible stock items. These findings were confirmed in interview with the facility Maintenance Director at the time of observation.	K0355	K355- Portable Fire Extinguishers 1.The facility failed to ensure portable fire extinguishers are selected, installed, inspected and maintained in accordance with NFPA 10. a.Fire Extinguisher by the counter in the Physical Therapy Charting Room is clear of combustible stock items. 2. Maintenance Director and Staff will be educated on the importance of keeping fire extinguishers free from obstruction and clear of combustible stock items. 3.To ensure continued compliance, the Maintenance director/designee will complete random audits 5x a week for 4 weeks. Findings will be reported to the QAPI committee. 4. The facility Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 5/13/2025 and for sustained compliance thereafter.	5/13/2025
K0374 SS= E	Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid	K0374	K374 – Subdivision of Building Spaces-Smoke Barrier 1.The facility failed to ensure smoke barriers	5/13/2025

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SHOREPOINTE NURSING CENTER	**26001 EAST JEFFERSON AVENUE SAINT CLAIR SHORES, MI 48081**

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	bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoke barrier doors meet the requirements of the LSC. This deficient practice could affect 58 of 175 facility residents in the event of a fire. Findings Include:1) On April 14, 2025 at 10:16 AM, observation revealed the fire-rated cross corridor door at the 2nd floor (new) storage room with roof access failed to positively when tested. 2) On April 14, 2025 at 12:07 PM, observation reveled the fire-rated double door set to Physical Therapy (new) failed to positively latch when tested. 3) On April 14, 2025 at 12:16 PM, observation revealed the doors the Physical Therapy storage require self-closure devices. 4) On April 14, 2025 at 2:26 PM, observation revealed the door to the 2nd floor sitting room failed to positively latch when tested.		doors meet the requirements of the LSC. a. Self-closers have been added to The Physical Therapy Storage doors. b. The fire-rated cross corridor door at the 2nd floor storage room with roof access has been repaired. c. The 2nd Floor Sitting Room door latch has been repaired. d. The latch to Physical Therapy double doors has been repaired. 2.The maintenance director and staff will be educated on the importance of the LSC requirements of various doors in the facility latch properly. 3.To ensure compliance is maintained, the maintenance director/designees will complete random audits 3x a week for 4 weeks. Findings will be reported to the QAPI committee. 4.The facility Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 5/13/2025 and for sustained compliance thereafter.	

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	These findings were confirmed with the facility Maintenance Director at the time of observation.			
K0511 SS= F	Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure equipment using gas or gas-related piping complies with NFPA 54, and electrical wiring and equipment complies with NFPA 70. This deficient practice could affect all 175 facility residents in the event of a fire resulting from sparks, arches or overheating of electrical equipment. Findings Include: 1) On April 14, 2025 at 12:09 PM, observation revealed combustible stock items stored within 3' of the electrical panels in the Physical Therapy storage. 2) On April 14, 2025 at 3:03 PM, observation revealed the electrical panel in the 2nd floor electrical closet by Room #263 has the cover disassembled and resting on the floor. 3) On April 14, 2025 at 3:39 PM, observation revealed 2 open blanks in the electrical panel for the 1st floor auxiliary kitchen in the 1st floor mechanical room.	K0511	K511 – Utility's-Gas and Electric. 1.The facility failed to ensure equipment using gas or gas related piping complies with NFPA 54 and electrical wiring and equipment complies with NFPA 70. a. The combustible stock items stored within 3' of the electrical panels in the Physical Therapy Storage have been removed. b. The electrical panel in the 2nd floor electrical closet by room #263 has been reassembled. c. The Electrical Panel for the 1st floor auxiliary kitchen in the 1st floor mechanical room with 2 open blanks has been corrected. d. The combustibles stored within 3' of the electrical panel in the 1st floor mechanical room have been removed. e. The combustibles stored on top of the transformer in the 1st floor mechanical room have been removed 2.The maintenance director and staff will be educated on maintaining clearance of 3' of electrical panels and transformers, and the panels are properly assembled and maintained withing the requirements of NFPA 54 and 70. 3.To ensure compliance is maintained, the maintenance director/designee will complete a random audit 5x a week for 4 weeks. Findings will be reported to the QAPI committee. 4.The facility Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 5/13/2025 and for sustained compliance thereafter.	5/13/2025

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	4) On April 14, 2025 at 3:40 PM, observation revealed combustibles stored within 3' of the electrical panel in the 1st floor mechanical room. 5) On April 14, 2025 at 4:37 PM, observation revealed combustible stock items stored on top of and within 3' of the transformer in the 1st floor mechanical room. These findings were confirmed with the facility Maintenance Director at the time of observation.			

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K0521 SS= F	HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure heating, ventilation and air conditioning is in compliance with 9.2. This deficient practice could affect all 175 facility residents in the event of a fire. Findings Include: On April 15, 2025 at 3:38 PM, record review revealed the facility failed to proved evidence of the required quadrennial (every 4 - years) serving and inspection of their installed Fire Dampers. The last recorded servicing was dated: 6/16/2020. No compliance supporting documentation was presented to surveyor by the time of exit. These findings were confirmed with the facility Maintenance Director at the time of record review.	K0521	K521 – HVAC 1. The facility failed to ensure heating, ventilation, and air conditioning in compliance with 9.2. a. The facility scheduled the required quadrennial serving and inspection of the installed Fire Dampers. 2. The Maintenance Director was educated on the required quadrennial serving and inspection of the installed fire dampers and proper documentation following required fire drills. 3. To ensure compliance is maintained, the Maintenance Director/designee will complete an audit monthly following each fire drill with proper documentation. Findings will be reported to the QAPI committee. 4. The facility Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 5/13/2025 and for sustained compliance thereafter.	5/13/2025
K0711 SS= F	Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2	K0711	K711 – Evacuation and Relocation Plan. 1. The facility failed to ensure there is a written plan for the protection of all residents and for their evacuation in the event of an emergency, employees are periodically instructed in their duties under the plan as required by 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3. a. The facility will schedule annual education	5/13/2025

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	and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure there is a written plan for the protection of all residents and for their evacuation in the event of an emergency, employees are periodically instructed in their duties under the plan as required by 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2 and 19.7.2.3. This deficient practice could affect all facility residents in the event of a fire or other emergency situation. Findings Include: On April 14, 2025 at 11:16 AM, during interview, nursing staff at the 2nd floor (new) nurse station were asked by the surveyor if they had received periodic training since their employment at the facility on the procedures for the removal of residents from elevated floors to the ground level in the event that the elevators were not operable and/or during a fire situation. All nursing staff at the nurse station stated they had not been trained on such procedures since their respective employment at the facility. These findings were confirmed in interview with the facility Maintenance Director at the time of observation.		and drill for the evacuation of residents from elevated floors to the ground level. 2. The Administrator/safety committee will be educated on the importance of routinely educating and scheduling drills of the evacuation of residents from elevated levels to the ground. 3. To ensure compliance is maintained, the Administrator will complete audits monthly to ensure staff are educated on the evacuation of residents from elevated levels. Findings will be reported to the QAPI committee. 4. The facility Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 5/13/2025 and for sustained compliance thereafter.	

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K0712 SS= F	Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to conduct fire drills as required by 19.7.1.4 through 19.7.1.7. This deficient practice could affect all 175 facility residents in the event of a fire situation. Findings Include: On April 15, 2025 at 12:53 PM, record review revealed the facility failed to conduct their required fire drills at unexpected time under varying conditions. The fire drill from the 2nd Quarter 2024 to present for the 1st Shift were as follows: 5/29/2024 at 11:30 AM, 8/25/2024 at 11:30 AM, and 11/25/2024 at 11:45 AM and 2/25/2025 at 12:00 PM; 2nd Shift 2nd Quarter 2024 to present: 6/25/2024 at 3:35 PM, 9/25/2024 at 3:30 PM, 12/24/2024 at 3:30 PM, and 3/25/2025 at 4:00 PM. These findings were confirmed with the facility Maintenance Director at the time of record review.	K0712	K712- Fire Drills 1. The facility failed to conduct fire drills as required by 19.7.1.4 through 19.7.1.7. a. The facility conducted a fire drill at an unexpected time and under varying conditions from the previous month/quarter. 2.The Maintenance Director was educated on the importance of running fire drills at unexpected times and under vary conditions from previous drills. 3.To ensure substantial compliance, the Administrator will do and audit of fire drills monthly for the 6 months. Findings will be reported to the QAPI committee. 4.The facility Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 5/13/2025 and for sustained compliance thereafter.	5/13/2025
K0918	Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric	K0918	K918 – Electrical Systems- Essential	5/13/2025

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SS= F	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 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 record review, observation and interview, the facility failed to ensure generators or other alternative power source are in accordance with NFPA 110, NFPA 99,		1. The facility failed to ensure generators or other alternative power source are in accordance with NFPA 110, NFPA 99, NFPA 111, and NFPA 70. a. The installed emergency backup power generators were supplied with lock/denying devices. b. The new emergency back-up power generator has had its annual 90-minute load back test and inspection has been scheduled. c. The monthly load run test and inspection has been performed and documented on the new generator. d. The annual fuel analysis for the stored diesel fuel for the emergency back-up power generator has been completed. 2. The maintenance director and staff were educated on weekly, monthly, and annually required generator tests as well as proper documentation according to NFPA standards. 3. To maintain continued compliance, Maintenance Director or designee will complete a random audit week for 4 weeks to ensure the NFPA standards are being met. Findings will be reported to the QAPI committee. 4. The facility Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 5/13/2025 and for sustained compliance thereafter.	

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	NFPA 111 and NFPA 70. This deficient practice could affect all 175 facility residents in the event of loss of commercial power to the facility. Findings Include: 1) On April 14, 2025 at 11:57 AM, observation revealed the access panels for both of the facility's installed emergency backup power generators were not secured with the supplied handle locks or other access denying device as required. This could potentially result in unintentional electrocution of unauthorized personnel and/or malicious tampering of this critical life safety component rendering it inoperable. These findings were confirmed in interview with the facility Maintenance Director at the time of observation. 2) On April 15, 2025 at 3:45 PM, record review revealed the facility failed to provide evidence of the required Annual Servicing Date and Annual 90 - Minute Load Bank Test Date of their installed emergency back-up power generator set. The generators (1 ea) initial service date was January 10, 2024. 3) On April 15, 2025 at 3:50 PM, record review revealed the facility failed to provide evidence of the required Monthly Load Test of their installed generator set from February 2024 to present. 4) On April 15, 2025 at 3:54 PM, record review revealed the facility failed to provide evidence of the required annual Fuel Analysis for the stored diesel fuel for their installed emergency back-up power generators fuel tanks from 2024 to present.			

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	No compliance supporting documentation was presented to the surveyor by the time of exit. These findings were confirmed with the facility Maintenance Director at the time of record review.			
K0923 SS= E	Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility	K0923	K923 – Gas Equipment- Cylinder and Container Storage. 1.The facility failed to ensure storage of nonflammable gasses meet all requirements of NFPA 99. a.Oxygen cylinders within 5' was cleared of combustible stock items on the 2nd floor of new side clean linen room. 2.Maintenance Director and staff were educated on the proper Oxygen cylinder storage requirements. 3.To ensure continued compliance, Maintenance Director/designee will complete random audits 5x a week for 4 weeks to ensure oxygen rooms and linen closets have proper storage of oxygen cylinders. Findings will be reported to the QAPI committee. 4.The facility Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 5/13/2025 and for sustained compliance thereafter.	5/13/2025

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	employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure storage of nonflammable gasses meet all requirements of NFPA 99. This deficient practice could affect 76 of 175 facility residents in the event of a fire emergency. Findings Include: On April 14, 2025 at 10:35 AM, observation revealed oxygen clylinders stored within 5' of combustable stock items in the 2nd floor (new) clean linen room. These findings were confirmed with the facility Maintenance Director at the time of observation.			