STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134140	A. BUILDING ______ B. WING ______	5/8/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE CARE OF BATTLE CREEK	**675 WAGNER DR BATTLE CREEK, MI 49017**

(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 May 7th and 8th, 2025, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey Pinnacle Care of Battle Creek was found to be not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		
E0039 SS= F	EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is	E0039	E039 1. The Administrator will conduct a review of the Emergency Preparedness plan and policies. The Maintenance Director will participate in/ conduct a community or facilitybased exercise to test the Emergency Preparedness system. 2. The Administrator will review regulation E039 and provide education to the Maintenance team on the requirements. 3. The Maintenance Director and/or designee will utilize the preventative maintenance system to ensure exercises are scheduled annually. Results of the annual exercise will be brought to the Quality Assurance Performance Improvement meetings for review. The Committee will determine whether modifications to the plan are necessary. 4. The Administrator is responsible to attain and maintain compliance. Completion date for compliance will be 06.20.25.	6/20/2025

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

Electronically Signed — 06/06/2025

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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	not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a			

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	group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise			

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	that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. * [For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the			

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	emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based			

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	functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency			

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	events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a			

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	facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually and analyze the response to and maintain documentation of all drills, tabletop exercises and emergency events. This deficient practice could affect all occupants in the event of facility emergency.			

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	Findings Include: On 05/07/2025 at approximately 1:00 PM, record review revealed the facility did not conduct an exercise either a second full-scale exercise, tabletop or individual facility based that would qualify as a test of the emergency plan within the past year. No documents were provided by survey exit. This finding was confirmed by interview with Facility Maintenance Director at the time of record review.			

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K0000 SS=	INITIAL COMMENTS On May 7th and 8th, 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, Pinnacle Care of Battle Creek 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 one story with partial basement building of Type I (332) construction, built in 1968. There were two additions added to the original facility one in 1985, of Type I (111) and one in 1993, of Type I (332) construction. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 82 certified beds. At the time of the survey the census was 61.	K0000		
K0100 SS= E	General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General 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. This REQUIREMENT is not met as evidenced by:	K0100	K100 1. The Maintenance Director and/or designee will remove the constructed wall between the Activity Office and Dietary. 2. The Administrator will review regulation K100 and provide education to the Maintenance team on the requirements. 3. The Maintenance Director and/or designee will conduct weekly rounds of the community spaces to ensure no lack of suppression coverage, and no new	6/20/2025

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	Based on observation and interview, the facility failed to failed to submit plans to the Bureau of Fire Services, as required by 18.1 and 19.1. This deficient practice could affect 30 occupants in the event of a fire emergency. In violation of the Health Care Facilities Fire Safety Rules, R 29.1804 Plans and specifications. Rule 4. (1) A health care facility, or designated representative, shall submit plans and specifications to the bureau of fire services for all projects that involve construction, remodeling, renovation, modification, reconstruction, or an addition. Findings Include: On 05/08/25 at approximately 8:31 AM, observation revealed a newly constructed wall built between Activities Office and Dietary Office. Wall located in the Activities office was a diagonal wall from the south part of the room to the north part of the room. Wall constructed in the Dietary Office was a straight wall from the south wall to the north wall. The reconstruction of the newly constructed walls left a void spot at the biggest span approximately 3 feet wide with unknown suppression coverage in this void area. No plans for this newly constructed wall was provided to this surveyor upon request. No plans for the newly constructed wall was provided by the exit of the survey. This finding was confirmed by interview with Facility Maintenance Director and Facility Maintenance at the time of observation.		construction is completed without prior approval. Results of the audits will be brought to the Quality Assurance Performance Improvement meeting monthly for review. The Committee will be responsible for any changes to the auditing process. 4. The Administrator is responsible to attain and maintain compliance. Completion date for compliance will be 06.20.25.	

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K0331 SS= F	Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). ______ This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure interior wall and ceiling finishes have a flame spread rating of Class A or B, unless permitted to be reduced by 10.2.8.1, as required by 19.3.3.1 and 19.3.3.2. This deficient practice could affect all occupants in the event of a fire emergency. Findings Include: 1. On 05/08/25 at approximately 8:06 AM, observation revealed ceiling tile has a 1" gap between the base of the exit sign and the ceiling tile. This deficiency is located at the entrance of the South Hall smoke compartment doors just after the Administrator's office. 2. On 05/08/25 at approximately 8:17 AM, observation revealed ceiling tile has a 1" gap between the base of the exit sign and the ceiling tile. This deficiency is located at the entrance of the North Hall smoke compartment doors just after the Director of Nursing office. These findings were confirmed by Facility Maintenance Director at the time of observation.	K0331	K331 1. The Maintenance Director and/or designee will repair the gaps between the ceiling tiles and exit signage at the entrance of South Hall and North Hall. 2. The Administrator will review regulation K331 and provide education to the Maintenance team on the requirements. 3. The Maintenance Director and/or designee will conduct weekly rounds of the community to ensure no gaps in the ceiling tiles. Results of the audits will be brought to the Quality Assurance Performance Improvement meeting monthly for review. The Committee will be responsible for any changes to the auditing process. 4. The Administrator is responsible to attain and maintain compliance. Completion date for compliance will be 06.20.25.	6/20/2025

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K0341 SS= F	Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a fire alarm system is installed in accordance with NFPA 70 and NFPA 72. This deficient practice could affect all occupants in the event of a fire emergency. Findings Include: 1. On 05/08/2025, at approximately 8:17 AM, observation revealed the smoke detector head at the North Smoke Doors exit into the administration hall was not properly mounted to the ceiling. 2. On 05/08/25 at approximately 8:48 AM, observation revealed the smoke detector head located in the North Mechanical closet had a plastic bag tapped over it. These findings were confirmed by interview with Facility Maintenance Director at the time of the observations.	K0341	K341 1. The Maintenance Director and/or designee will repair the smoke detector heads at the North smoke doors and North mechanical closet. 2. The Administrator will review regulation K341 and provide education to the Maintenance team on the requirements. 3. The Maintenance Director and/or designee will conduct a weekly community audit of smoke detectors to ensure appropriate function. Results of the audits will be brought to the Quality Assurance Performance Improvement meeting monthly for review. The Committee will be responsible for any changes to the auditing process. 4. The Administrator is responsible to attain and maintain compliance. Completion date for compliance will be 06.20.25.	6/20/2025

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	134140	A. BUILDING ______ B. WING ______	5/8/2025

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K0353 SS= E	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 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 approximately 30 occupants in the event of a fire emergency. Findings Include: 1. On 05/07/2025, at approximately 12:23 PM, record review revealed the the facility failed to provided the 2nd, 3rd, and 4th quarter sprinkler flow test. No test were provided by the exit of the survey. 2. On 05/08/2025, at approximately 9:58 AM, observation revealed a sprinkler head in the therapy room was dated 1967. This sprinkler head	K0353	K353 1. The Maintenance Director and/or designee will conduct a sprinkler flow test and replace the sprinkler head in the Therapy room. 2. The Administrator will review regulation K353 and provide education to the Maintenance team on the requirements. 3. The Maintenance Director and/or designee will ensure sprinkler system maintenance is scheduled for the remainder of 2025. The Maintenance Director and/or designee will ensure the Preventative Maintenance system flags for sprinkler system maintenance to ensure compliance. Results of sprinkler system testing will be brought to the Quality Assurance Performance Improvement meeting monthly for review. 4. The Administrator is responsible to attain and maintain compliance. Completion date for compliance will be 06.20.25	6/20/2025

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	is over 50 years old. These findings were confirmed by interview with Facility Maintenance Director at the time of observation.			
K0363 SS= F	Corridor - Doors 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 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	K0363	K363 1. The Maintenance Director and/or designee will repair the North Dining Room doors to ensure a positive latch, along with the gap in resident room 125 door. 2. The Administrator will review regulation K363 and provide education to the Maintenance team on the requirements. 3. The Maintenance Director and/or designee will conduct weekly rounds of doors protecting corridor openings to ensure no gaps and that doors close to a positive latch. Results of the audits will be brought to the Quality Assurance Performance Improvement meeting monthly for review. The Committee will be responsible for any changes to the auditing process. 4. The Administrator is responsible to attain and maintain compliance. Completion date for compliance will be 06.20.25.	6/20/2025

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	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 ensure doors protecting corridor openings are capable of resisting the passage of smoke as required by NFPA 19.3.6.3. This deficient practice could affect all occupants in the event of a fire emergency. Findings Include: 1. On 05/08/25, at approximately 8:57 AM, observation revealed the North Dining Room door across from resident room 125 would not latch when tested. Latch was missing from the door not allowing the door to properly latch. 2. On 05/08/25, at approximately 8:59 AM, observation revealed the North Dining Room door across from resident room 107 would not latch when tested. 3. On 05/08/25, at approximately 9:19 AM, observation revealed Resident Room 125 had a 2" gap between the door and the floor. These findings were confirmed by interview with Facility Maintenance Director at the time of the observations.			

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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 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 30 occupants in the event of a fire emergency. Findings Include: On 05/08/25, at approximately 8:41 AM, observation revealed smoke compartment door #9 would not close to a smoke tight fit when tested. Door sweep on the bottom of the door was catching on the floor preventing the door to release properly to close. Door would not close without assistance from staff to move from the mag release. This finding was confirmed by interview with Facility Maintenance Director at the time of observation.	K0374	K374 1. The Maintenance Director and/or designee will repair the smoke compartment door #9 to ensure it closes properly to prevent the passage of smoke. 2. The Administrator will review regulation K374 and provide education to the Maintenance team on the requirements. 3. The Maintenance Director/ designee will conduct a weekly round of smoke compartment doors to ensure they close properly. The Maintenance Director will ensure rounding is logged into the Preventative Maintenance program to ensure continued assessment of function. Results of the audits will be brought to the Quality Assurance Performance Improvement meeting monthly for review. The Committee will be responsible for any changes to the auditing process. 4. The Administrator is responsible to attain and maintain compliance. Completion date for compliance will be 06.20.25.	6/20/2025
K0918	Electrical Systems - Essential Electric Syste	K0918	K918	6/20/2025

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SS= F	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 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 and interview, the facility failed to ensure generators or other alternative power source are in accordance with NFPA 110,		1. The Maintenance Director and/or designee will schedule monthly generator load testing, annual load bank, service, and fuel analysis testing to be completed by the compliance date. 2. The Administrator will review regulation K918 and provide education to the Maintenance team on the requirements. 3. The Maintenance Director and/or designee will ensure the Preventative Maintenance system has all required generator testing scheduled to ensure regulatory compliance based upon education for tag 0918. Results of the required testing will be brought to the Quality Assurance Performance Improvement meetings for review. The Committee will determine whether modifications to the plan are necessary. 4. The Administrator is responsible to attain and maintain compliance. Completion date for compliance will be 06.20.25.	

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	NFPA 99, NFPA 111 and NFPA 70. This deficient practice could affect all occupants in the event of power failure. Findings Include: 1. On 05/07/2025, at approximately 2:24 PM, record review revealed the facility failed to provide a current generator monthly load test. Last monthly load test provided was August 2024. No current monthly load test were provided by the exit of the survey. 2. On 05/07/2025, at approximately 2:24 PM, record review revealed the facility failed to provide a current annual load bank test. No current annual load bank test was provided by the exit of the survey. 3. On 05/07/2025, at approximately 2:24 PM, record review revealed the facility failed to provide a current annual service documentation for the generator. No current annual service document was provided by the exit of the survey. 4. On 05/07/2025, at approximately 2:24 PM, record review revealed the facility failed to provide a current annual fuel analysis test for the fuel in the generator. No current fuel analysis testing document was provided by the exit of the survey.			
K0920 SS= E	Electrical Equipment - Power Cords and Extens 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	K0920	K920 1. The Maintenance Director and/or designee will replace the extension cord in the South Mechanical Room with an NFPA approved device. 2. The Administrator will review regulation K920 and provide education to the Maintenance team on the requirements. 3. The Maintenance Director and/or designee	6/20/2025

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	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 (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 ensure power strips are in compliance with NFPA 99 and NFPA 70. This deficient practice could affect 30 occupants in the event of a fire emergency. Findings Include: On 05/08/2025, at approximately 9:28 AM, observation revealed a green extension cord being used as permanent wiring. This extension cord is located in the South Mechanical Room. This extension cord is plugged into a wall outlet with the other end missing its female end, with wires spliced and wired into a call light box. This finding was confirmed by interview with Facility Maintenance Director at the time of observation.		will conduct a full community audit weekly to ensure any extension cord utilized is compliant with NFPA guidelines. Results of the audits will be brought to the Quality Assurance Performance Improvement meetings for review. The Committee will be responsible for any changes to the auditing process. 4. The Administrator is responsible to attain and maintain compliance. Completion date for compliance will be 06.20.25.	