STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365365	a. building BLD 02 b. wing	06/05/2025

name of provider or supplier	street address, city, state, zip code
URBANA HEALTH & REHABILITATION CENTER	741 E WATER STREET URBANA OH, 43078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED 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
K 0000	INITIAL COMMENTS	K 0000		
BLD02	FIRE SAFETY SURVEY REPORT 2012 EXISTING CODE ADMINISTRATOR: Tonya Blumenschein, #7454 CENSUS: 46 BUILDING 1 OF 1 42 CFR 483. 90 (a) The facility must meet the applicable provisions of the 2012 Existing Edition of the Life Safety Code (LSC) of the National Fire Protection Association. An annual Life Safety Code survey was conducted by the Ohio Department of Health on June 5, 2025. At this survey, Urbana Health and Rehabilitation Center was found not to comply with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.90 (a) Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code, Chapter 19 Existing Health Care Chapter. The facility is a one-story building with a partial basement. The facility was built in 1969 and was determined to be a Type V [000] construction, fully sprinklered. The facility features a fire alarm system with smoke detection in corridors, open spaces adjacent to corridors, and hazardous areas. The facility features concrete flooring, exposed floor joists and			

laboratory director's or provider/supplier representative's signature	title	(x6) date
TONYA.BLUMENSCHEIN		07/16/2025

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K 0000	Continued From page 1 roof trusses, as well as a brick and siding exterior. The facility is a 50-bed Dually Certified nursing home. The requirement at 42 CFR Subpart 483.90 (a) is NOT MET as evidenced by:	K 0000		

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K 0291	Continued From page 2	K 0291		
K 0291 SS=F BLD02	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to maintain emergency lighting per NFPA 101-2012 Edition, Section 19.2.9.1, and NFPA 101-2012 Edition, Section 7.9.3.1.1. This had the potential to affect 46 residents. Findings include: During a record review of the life safety documentation in the black binder titled "Life Safety Binder 2, "on 06/05/25 at approximately 12:11 P.M., there was no documentation that the seven emergency lights were tested for at least 90 minutes on an annual basis. An interview with MD#1 confirmed the finding at the time of discovery, stating that he was unaware of the requirements. NFPA 101-2012 Edition, Section 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. NFPA 101-2012 Edition, Section 7.9.1.1* Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following: (1) Buildings or structures where required in Chapters 11 through 43	K 0291	K291 Urbana Health and Rehab wishes to point out to any person who reviews this document that we do not necessarily agree with the citations with which we were cited. However, the law requires us to prepare a plan of correction for the citations regardless of whether we agree with them or not. Thus, we have prepared such a plan as noted below. Please note though, that this plan does not constitute an admission that the citations are either legally or factually correct. This plan of correction is not meant to establish any standard of care, contract, obligation, or position and Urbana Health and Rehab reserves all rights to raise all possible contentions and defenses in any civil or criminal action or proceeding. Please accept 07/30/25 as the facility's allegation of compliance date. The facility failed to complete annual 90 minute emergency light test. Step 1 Director of Maintenance to complete 90 minute test by (7/18/25). Step 2 Potential to effect all resident. Power outage 4/29/25 for 1 hour, no negative outcomes, generator worked properly. Step 3 NHA educated Maintenance Director on NFPA 101 Emergency Lighting 90 Minute Annual Testing by 7/15/25. Step 4 NHA to monitor emergency lighting test logs for continued compliance weekly x4 then monthly x2. Results of the audits will be forwarded to the facility QAPI committee for further review and recommendation.	07/30/2025

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K 0291	Continued From page 3 (2) Underground and limited access structures as addressed in Section 11.7 (3) High-rise buildings as required by other sections of this Code (4) Doors equipped with delayed-egress locks (5) Stair shafts and vestibules of smokeproof enclosures, for which the following also apply: (a) The stair shaft and vestibule shall be permitted to include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment. (b) The standby generator shall be permitted to be used for the stair shaft and vestibule emergency lighting power supply. (6) New access-controlled egress doors in accordance with 7.2.1.6.2 NFPA 101-2012 Edition, Section 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) *The test interval shall be permitted to be extended be- yond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 11?2 hours if the emergency lighting system is battery-powered. (4) The emergency lighting equipment	K 0291		

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K 0291	Continued From page 4 shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	K 0291		

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K 0363	Continued From page 5	K 0363		
K 0363 SS=E BLD02	NFPA 101 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	K 0363	K363 Urbana Health and Rehab wishes to point out to any person who reviews this document that we do not necessarily agree with the citations with which we were cited. However, the law requires us to prepare a plan of correction for the citations regardless of whether we agree with them or not. Thus, we have prepared such a plan as noted below. Please note though, that this plan does not constitute an admission that the citations are either legally or factually correct. This plan of correction is not meant to establish any standard of care, contract, obligation, or position and Urbana Health and Rehab reserves all rights to raise all possible contentions and defenses in any civil or criminal action or proceeding. Please accept 07/30/25 as the facility's allegation of compliance date. The facility failed to ensure that resident room doors A9 and B12 would not latch. Step 1 Director of Maintenance fixed resident room doors A9 and B12 on 6/6/25. Step 2 Maintenance Director completed house audit to ensure that all resident doors latched properly when closed 6-6-25, no negative findings. Step 3 LNHA educated Director of Maintenance on corridor doors and safety to ensure proper functioning when closed 7/15/25. Step 4 NHA/designee will audit corridor room doors to ensure ongoing compliance weekly x4 then monthly x2. The results of the audits will be submitted to the QAPI Committee for further review and recommendations.	07/30/2025

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K 0363	Continued From page 6 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 STANDARD is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain corridor rooms per NFPA 101-2012 Edition, Section 19.3.6.3.1*. This had the potential to affect 17 out of 46 residents. Findings include: An observation during a tour of the facility on June 5, 2025, at approximately 1:34 P.M. revealed that residents' rooms A-9 and B-12 would not latch. Three attempts were made to latch the doors, but all were unsuccessful. An interview with MD#1 confirmed the finding at the time of discovery, stating that he was unaware of the requirements. NFPA 101-2012 Edition, Section 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: (1) 13?4 in. (44 mm) thick, solid-bonded core wood	K 0363		

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K 0363	Continued From page 7 (2) Material that resists fire for a minimum of 20 minutes NFPA 101-2012 Edition, Section 19.3.6.3.3 Compliance with NFPA 80, Standard for Fire Doors and Other Opening Protectives, shall not be required. NFPA 101-2012 Edition, Section 19.3.6.3.4 A clearance between the bottom of the door and the floor covering not exceeding 1 in. (25 mm) shall be permitted for corridor doors. NFPA 101-2012 Edition, Section 19.3.6.3.5* Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction, and the following requirements also shall apply: (1) The device used shall be capable of keeping the door fully closed if a force of 5 lbs. (22 N) is applied at the latch edge of the door. (2) Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.7.	K 0363		

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K 0372	Continued From page 8	K 0372		
K 0372 SS=E BLD02	NFPA 101 Subdivision of Building Spaces - Smoke Barrie 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 STANDARD is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain the fire/smoke wall per NFPA 101-2012 Edition, Section 19.3.7.3, and NFPA 101-2012 Edition, Section 8.5.6.2. This had the potential to affect five out of 46 residents. Findings include: An observation during a tour of the facility with Maintenance Director (MD) #1 on June 5, 2025, at approximately 1:08 P.M. revealed one grey wire and one white wire passing through the smoke wall unsealed in the intestinal space between the drop ceiling and ceiling of the building at the double corridor by room B-9.	K 0372	K0372 Urbana Health and Rehab wishes to point out to any person who reviews this document that we do not necessarily agree with the citations with which we were cited. However, the law requires us to prepare a plan of correction for the citations regardless of whether we agree with them or not. Thus, we have prepared such a plan as noted below. Please note though, that this plan does not constitute an admission that the citations are either legally or factually correct. This plan of correction is not meant to establish any standard of care, contract, obligation, or position and Urbana Health and Rehab reserves all rights to raise all possible contentions and defenses in any civil or criminal action or proceeding. Please accept 07/30/25 as the facility's allegation of compliance date. The facility failed to ensure smoke barrier in Rm #B9 would resist passage of smoke. Step 1 Penetrations in Rm#B9 were sealed to resist passage of smoke to prevent passage of smoke creating a sealed/contained smoke compartment 6-6-25. Step 2 All resident rooms audited for penetrations by 7/15/25. Step 3 Maintenance Director educated by LNHA on the smoke barrier function of the ceiling and maintaining the integrity of the ceiling 7/15/25. Step 4 To monitor and maintain compliance LNHA/designee will audit smoke barriers for compliance weekly for X4, then monthly X2. Results of the audits will be forwarded to the facility QAPI committee for further review and recommendation.	07/30/2025

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K 0372	Continued From page 9 An interview with MD#1 confirmed the finding at the time of discovery, stating that he was unaware of the requirements. NFPA 101-2012 Edition, Section 19.3.7.3 states, 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)(c). (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. NFPA 101-2012 Edition, Section 8.5.6.2 states, 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,	K 0372		

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K 0372	Continued From page 10 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.	K 0372		

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K 0374	Continued From page 11	K 0374		
K 0374 SS=E BLD02	NFPA 101 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 STANDARD is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain fire/smoke barrier doors per NFPA 101-2012 Edition, Section 19.3.7.8*, NFPA 101-2012 Edition, Section 19.2.2.2.7*, and NFPA 101-2012 Edition, Section 7.2.1.8.2. This had the potential to affect 13 out of 46 residents. Findings include: An observation during a tour of the facility on June 5, 2025, at approximately 1:33 P.M. revealed that the double corridor fire /smoke barrier door by the Director of Nursing office and room R1 was unable to	K 0374	K0374 Urbana Health and Rehab wishes to point out to any person who reviews this document that we do not necessarily agree with the citations with which we were cited. However, the law requires us to prepare a plan of correction for the citations regardless of whether we agree with them or not. Thus, we have prepared such a plan as noted below. Please note though, that this plan does not constitute an admission that the citations are either legally or factually correct. This plan of correction is not meant to establish any standard of care, contract, obligation, or position and Urbana Health and Rehab reserves all rights to raise all possible contentions and defenses in any civil or criminal action or proceeding. Please accept 07/30/25 as the facility's allegation of compliance date. The facility failed to maintain fire/smoke barrier doors by DON office and room R1. Fire/Smoke barrier door by A4 and A9 failed to close during test of fire alarm. Step 1 Maintenance Director repaired to doors by DON office and room R1 and A4 and A9 6-6-25. Step 2 Fire doors audits for compliance by Maintenance Director 6-6-25, no negative findings. Step 3 Maintenance Director educated by LNHA on the Fire/Smoke Barrier Doors by 7-15-25. Step 4 To monitor and maintain compliance LNHA/designee will audit fire/smoke barriers doors for compliance weekly for X4, then monthly X2. Results of the audits will be forwarded to the facility QAPI committee for further review and recommendation.	07/30/2025

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K 0374	Continued From page 12 close. Additionally, the fire/smoke barrier door in resident rooms A-4 and A-9 failed to close correctly. During a test of the fire alarm at approximately 1:58 P.M., the doors was also unable to close completely. An interview with MD#1 confirmed the finding at the time of discovery, stating that he was unaware of the requirements. NFPA 101-2012 Edition, Section 19.3.7.8* Doors in smoke barriers shall comply with 8.5.4 and all of the following: (1) The doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.7. (2) Latching hardware shall not be required (3) The doors shall not be required to swing in the direction of egress travel. NFPA 101-2012 Edition, Section 19.2.2.2.7* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2, shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility. NFPA 101-2012 Edition, Section 7.2.1.8.2 In any building of low or ordinary hazard	K 0374		

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K 0374	Continued From page 13 contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, door leaves shall be permitted to be automatic closing provided that all of the following criteria are met: (1) Upon release of the hold-open mechanism, the leaf becomes self-closing. (2) The release device is designed so that the leaf instantly releases manually and, upon release, becomes self-closing, or the leaf can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door leaf release service in NFPA 72, National Fire Alarm and Signaling Code. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released, and the door leaf becomes self-closing. (5) The release by means of smoke detection of one door leaf in a stair enclosure results in closing all door leaves serving that stair.	K 0374		

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K 0741	Continued From page 14	K 0741		
K 0741 SS=E BLD02	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain smoking areas per NFPA 101-2012 Edition, Section 19.7.4*. This had the	K 0741	K741 Urbana Health and Rehab wishes to point out to any person who reviews this document that we do not necessarily agree with the citations with which we were cited. However, the law requires us to prepare a plan of correction for the citations regardless of whether we agree with them or not. Thus, we have prepared such a plan as noted below. Please note though, that this plan does not constitute an admission that the citations are either legally or factually correct. This plan of correction is not meant to establish any standard of care, contract, obligation, or position and Urbana Health and Rehab reserves all rights to raise all possible contentions and defenses in any civil or criminal action or proceeding. Please accept 7/30/25 as the facility's allegation of compliance date. The facility failed to ensure safe smoking as evidence by cigarette butts on the ground around staff smoking area, lining the emergency lane parking, yellow line on sidewalk, floor of employee smoking area, in front of storage area that stored combustible materials. Additionally, there were no self-closing metal containers into which ashtrays could be emptied. Step 1 Director of Maintenance cleaned the staff smoking area on 6-6-25. A 16 qt. covered, self-closing, metal receptacle, was obtained for placement of cigarette butts and placed in smoking area 6/15/25. Step 2 Audit was completed by DON/ADON on designated smoking areas 6-6-25 for compliance issues, no negative findings. Step 3 All staff educated on NFPA 101 Smoking Regulations: safe smoking practices and the importance of proper disposal of used smoking materials in	07/30/2025

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K 0741	Continued From page 15 potential to affect 22 of 46 residents who reside within the facility. Findings include: An observation during a tour of the facility on June 5, 2025, at approximately 1:48 p.m. revealed numerous cigarettes, exceeding 50, in the back of the facility, lining the emergency lane parking area and the yellow line on the sidewalk. Additionally, innumerable cigarettes were scattered on the floor of the employee smoking area, located in front of the storage area, which contained combustible materials, including chairs and shelving. The employee storage also did not contain metal containers with self-closing cover devices into which ashtrays can be emptied, provided that ashtrays are provided. An interview with MD #1 confirmed the finding at the time of discovery, stating that he had informed many people about it, but they would only act if it were written up. NFPA 101-2012 Edition, Section 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or individual enclosed space where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read	K 0741	appropriate receptacles on 6-24-25. New hires educated upon orientation. Step 4 To monitor and maintain ongoing compliance the LNHA/designee with audit the staff smoking area weekly x4 then monthly x2. The results of the audits will be submitted to the QAPI committee for further review and recommendations.	

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K 0741	Continued From page 16 NO SMOKING or shall be posted with the international symbol for no smoking. (2) In healthcare occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 19.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available in all areas where smoking is permitted.	K 0741		

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K 0918	Continued From page 17	K 0918		
K 0918 SS=F BLD02	NFPA 101 Electrical Systems - Essential Electric Syste 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.	K 0918	K918 Urbana Health and Rehab wishes to point out to any person who reviews this document that we do not necessarily agree with the citations with which we were cited. However, the law requires us to prepare a plan of correction for the citations regardless of whether we agree with them or not. Thus, we have prepared such a plan as noted below. Please note though, that this plan does not constitute an admission that the citations are either legally or factually correct. This plan of correction is not meant to establish any standard of care, contract, obligation, or position and Urbana Health and Rehab reserves all rights to raise all possible contentions and defenses in any civil or criminal action or proceeding. Please accept 07/30/25 as the facility's allegation of compliance date. The facility failed to ensure that the 4 hour 36 month load test was completed on the generator and written record of maintenance and testing was logged incorrectly. Step 1 Facility Administrator obtained the 4 hour bank test documentation from 6/9/2023. Step 2 NHA audited the generator testing log for the time meter reading-start and end ensuring that it would include hours of the engine not the test start and end time. Maintenance Director corrected log entry for month of July 2025. Step 3 NHA educated Maintenance Director on correct way to log generator testing entries 7/15/25.	07/30/2025

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K 0918	Continued From page 18 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain the diesel generator per NFPA 110-2010 Edition, Section 8.4.9*, NFPA 110 Edition, Section 8.4.9.1, NFPA 110 Edition, Section 8.4.9.2, NFPA 110 Edition, Section 8.4.9.3, NFPA 110 Edition, Section 8.4.9.5.1, NFPA 110 Edition, Section 8.4.9.6, and NFPA 110 Edition, Section 8.4.9.7. This had the potential to affect all 46 residents. Findings include: During a record review of the life safety documentation in the black binder titled "Life Safety Binder 2, "on 06/05/25 at approximately 12:11 P.M., it was revealed that the last time a four-hour load bank test had been completed was 06/08/21. Additionally, the "Time Meter Reading - Start and End" column of the monthly test did not include the hours of the engine but rather indicated the time the test started and ended. An interview with the Maintenance Director (MD) #1 confirmed the findings at approximately 12:15 P.M., stating that he was unaware of the requirement and unsure of its details. NFPA 110-2010 Edition, Section 8.4.9* Level 1 EPSS shall be tested at least	K 0918		

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K 0918	Continued From page 19 once within every 36 months. NFPA 110 Edition, Section 8.4.9.1 Level 1 EPSS shall be tested continuously for the duration of its assigned class (see Section 4.2). NFPA 110 Edition, Section 8.4.9.2 Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. NFPA 110 Edition, Section 8.4.9.3 The test shall be initiated by operating at least one transfer switch test function and then by operating the test function of all remaining ATSs, or initiated by opening all switches or breakers supplying normal power to all ATSs that are part of the EPSS being tested. NFPA 110 Edition, Section 8.4.9.5.1 For a diesel-powered EPS, loading shall be not less than 30 percent of the nameplate kW rating of the EPS. A supplemental load bank shall be permitted to be used to meet or exceed the 30 percent requirement. NFPA 110 Edition, Section 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. NFPA 110 Edition, Section 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.	K 0918		

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K 0918	Continued From page 20	K 0918		
K 0923 SS=E BLD02	NFPA 101 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	K 0923	K923 Urbana Health and Rehab wishes to point out to any person who reviews this document that we do not necessarily agree with the citations with which we were cited. However, the law requires us to prepare a plan of correction for the citations regardless of whether we agree with them or not. Thus, we have prepared such a plan as noted below. Please note though, that this plan does not constitute an admission that the citations are either legally or factually correct. This plan of correction is not meant to establish any standard of care, contract, obligation, or position and Urbana Health and Rehab reserves all rights to raise all possible contentions and defenses in any civil or criminal action or proceeding. Please accept 7/30/25as the facility's allegation of compliance date. The facility failed to maintain oxygen storage signage near room A13, empty oxygen bottle were labeled "partial/empty". Step 1 Maintenance Director corrected the signage on 6-6-25 with a sign that reads "Empty". Step 2 All resident that utilize oxygen assessed for proper storage and placement of oxygen tanks by 7/15/25. Step 3 LNHA educated all clinical staff on appropriate signage for Oxygen room 7/15/25. New hires educated upon orientation. Step 4 LNHA/designee to monitor for continued compliance will audit oxygen room signage weekly x4 then monthly x2. Results of the audits will be forwarded to the QAPI committee for further review and recommendations.	07/30/2025

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K 0923	Continued From page 21 the supplier. Empty cylinders are segregated from full cylinders. When facility 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 STANDARD is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain oxygen storage per NFPA 99-2012 Edition, Section 11.6.5.2. This had the potential to affect eight out of 46 residents. Findings include: An observation during a tour of the facility on June 5, 2025, at approximately 1:44 P.M. revealed that inside the oxygen storage area near A-13 room, there were two signs inside the room stating "full" and "partial/empty". The facility did not define what they considered partial, which had the potential to lead to putting cylinders that were almost full in the empty section. An interview with MD#1 confirmed the finding at the time of discovery, stating that he was unaware of the requirements and thought the sign was confusing. NFPA 99-2012 Edition, Section 11.6.5.2	K 0923		

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K 0923	Continued From page 22 states that if empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders.	K 0923		