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 _____	3/18/2024

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 March 12-13, 2024, 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 not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		
E0006 SS= F	Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events	E0006	E006 Element #1 No residents were cited in this tag. The Administrator reviewed and updated the facility Emergency Preparedness Plan and Risk assessment on 10/2/2023, any further updates will be updated by 4/22/2024. Element #2 his deficient practice has the potential to affect all occupants in the event of an emergency. Element #3 The Emergency Preparedness was reviewed and deemed appropriate by the QAPI Committee on 3/26/2024. The Administrator received a 1:1 in-service on the importance of reviewing and updating the Emergency Preparedness plan and risk assessment annually on 4/5/2024 by the Governing Board. Element #4 The Administrator or designee will audit the	4/22/2024

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

Electronically Signed | 04/07/2024

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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	identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain an Emergency Preparedness plan that must be reviewed and updated annually and be based on and include a documented, facility-based and community based risk assessment, utilizing an all-hazards approach, including missing residents, and include strategies for addressing emergency events identified by the risk assessment. This deficient practice could affect all occupants in the event of an		Emergency Preparedness Manual once a month, for 3 months, and then annually. Results of the audit will be reported to monthly QAPI. The Administrator is responsible for maintaining compliance. The Compliance date is 4/22/2024.	

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	emergency. Findings Include: On 03/12/2024 at approximately 1:27 PM, record review revealed the facility failed to conduct a facility-based and community-based risk assessment. No facility-based or community-based risk assessment was provided by the exit of the survey. This finding was confirmed by interview with Facility Administrator.			

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K0000 SS=	INITIAL COMMENTS On March 12-18, 2024, 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 addition 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 52. The requirement at 42 CFR, subpart 483.90 (a) is NOT MET as evidenced by:	K0000		
K0111 SS= K	Building Rehabilitation Building Rehabilitation Repair, Renovation, Modification, or Reconstruction Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: * Requirements of Chapter 18 and 19 * Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 Change of Use or	K0111	Element #1 The facility was assessed for Structural Stability on 3/15/2024 by a structural Engineer. The building and resident areas were deemed stable. The Following will be completed by 4/22/2024: *Isolate area/wing of building under construction. *Remove existing 6070 door and infill w/steel	4/22/2024

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	Change of Occupancy Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7) Additions Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a 2-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2-hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a building undergoing repair, renovation, modification or reconstruction complies with the following: Requirements of Chapter 18 and 19; and Requirements of the applicable Sections 43.3, 43.4, 43.5 and 43.6, as required by 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1. The facility failed to get approval for the construction and modification of the facility, it's means of egress and the structural status of the building; failed to maintain the required 1-hour fire rating separation from the construction area to the occupied space, resulting in blocked exits and compromised smoke compartments. This deficient practice could affect 20 occupants in the		studs and 2 layers of 5/8 Type X drywall each side. *Tape and finish drywall per industry standard and achieve goal of isolating wing with fire/smoke wall. *Shim bottom of Floating partition walls to existing concrete slab to prevent excessive weight hanging from bottom of structural roof trusses. *Fire caulk/foam/grout between floating partitions and concrete slab to prevent air flow from the wing under construction and remainder of facility. *Install door sweep on the other remaining 6070 door. *Install Manual Lock on the other remaining door to prevent resident access to area under construction. Element #2 The facility has determined that all residents and staff have the potential to be affected by the deficient practice. Residents in rooms 148, 149, 150 were relocated on 3/12/24 to rooms 128,135, 137 with 2 means of egress to exit. Rooms 142-147 were not occupied. The soiled utility room was moved down the hall around the corner across from room 126. Pharmacy room has been moved to the North Unit Central Supply Room. The Therapy Gym was moved to the North Unit Activity Room, Harmony Hall Meeting Room was moved to the Admissions office off the Front Lobby. An inspection of the 1 - hour separation by Battle Creek Building Department will be completed by 4/22/24. Element #3 The Means of Egress-Corridors and Exits Policy was reviewed and deemed appropriate by the QAPI Committee on 3/13/2024. Facility staff were educated on 3/13/24 and	

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	event of a fire emergency. Findings Include: On 03/12/2024 at approximately 3:15 PM, observation revealed the facility failed to obtain approval from the State of Michigan or local authorities having jurisdiction for the construction and modification of the facility. At the south unit corridor, spanning across the corridor between rooms 143 and 145, an open trench with exposed dirt was observed obstructing the egress pathway to the south exit door. The concrete floor was cut out the width of the corridor, 3 feet wide, and 12 inches deep. This construction area was observed not separated from adjacent occupied spaces. During this time, an unidentified resident in a wheelchair was observed coming up to the unsecured smoke barrier doors to the construction area. This finding was confirmed with the Facility Maintenance at the time of observation. Interview with Facility Owner on 03/12/2024 at approximately 4:00 PM, and again on 03/13/2024 at approximately 10:29 AM, Facility Owner stated permits were pulled by the construction company. At no time was the required permits presented to this surveyor. No required permits for this construction project were provided to this surveyor by the exit of the survey. During interview with Facility Owner on 03/13/2024 at approximately 10:33 AM, Facility Owner stated the construction project started on June 6, 2023. The Immediate Jeopardy began on 06/06/2023, when construction began on the south hallway egress path. The Facility Administrator was notified of the Immediate Jeopardy on 03/13/2024 at 11:41 AM. The surveyor confirmed by observation and interview the Immediate		nonworking staff were educated on their next day of working. Element #4 The Maintenance Director or designee will audit the construction area 3 x weekly for 6 months for Building Safety. Results of the audits will be reported to monthly QAPI. The Administrator is responsible for maintain compliance. The Compliance Date is 4/22/2024	

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	Jeopardy was removed on 03/18/2024, but noncompliance remains at pattern, with potential for more than minimal harm that is not Immediate Jeopardy due to construction work that is incomplete and sustained compliance that has not been verified by the State Agency. The Immediate Jeopardy that began on 06/06/2023, was removed on 03/18/24 when the facility took the following actions to remove the immediacy: Identification of Residents Affected or Likely to be affected: 1. This affected 20 residents in the adjacent smoke compartments. 2. Immediate action was taken to ensure the safety of the 20 residents in the adjacent smoke compartments. Residents in rooms 148, 149,150 were moved on 3/12/2024 at 5:00pm, relocated to Rooms 128, 135, 137 with 2 means of egress to exit. Rooms 142-147 were not occupied by any residents. The Soiled Utility Room has been moved down the hall and around the corner, across from room 126. Pharmacy room has been moved to the North Unit Central Supply Room. The Therapy Gym has been moved to the North Unit Activity Room. Harmony Hall Meeting Room has been moved to The Admissions Office off the Front Lobby. 3. The Means of Egress-Corridors and Exits Policy was reviewed and deemed appropriate on 3/13/2024. 4. Working Staff were immediately in serviced on 3/13/2024 on The Construction Area and Means of Egress - Corridors and Exits. Non-working Staff were in serviced by phone and will be on next day of working.			

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	Actions to Prevent Occurrence/Recurrence: 5. No access or activity will be allowed in the areas of The Soiled Utility Room, Pharmacy Room, Therapy Gym, or Harmony Hall and rooms 142-150. 6. The facility was assessed on 3/15/2024: By a Structural Engineer 7. He assessed the stability of the rest of the building and resident areas. He deemed the facility structure stable. He gave recommendations to: Project Manager. To a designated Construction Services On 03/12/2024 at approximately 3:15 PM, observation revealed the smoke detector was covered with a plastic bag taped over it, in the middle of the corridor between rooms 143 and 145. On 03/12/2024 at approximately 3:15 PM, observation revealed room 145 and 146 doors have been removed from the hinges. These observations were confirmed by interview with Facility Maintenance at the time of observation.			
K0211 SS= K	Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:	K0211	K211 Pinnacle Care of Battle Creek is requesting a Temporary Waiver for this Citation CMS Justification: This request for Temporary Waiver will not adversely affect the health and safety of residents and staff at the Skilled Nursing Facility. This affected 3 residents on the hallway in rooms, 148, 149 and 150.2. Residents in room 148, 149 and 150 were moved on 3/12/2024	9/30/2024

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	Based on observation, record review and interview, the facility failed to ensure aisles, passageways, corridors, exit discharges, exit locations and accesses are in accordance with Chapter 7, and continuously maintained free of all obstructions to full use in case of an emergency as required by 19.2.1 and 7.1.10.1. This deficient practice could affect 20 occupants in the event of a fire emergency. Findings Include: 1. On 03/12/2024 at approximately 3:15 PM, observation revealed the Southeast Hall exit doors 5 and 6 (between Rehab/Therapy and Room 147) and South Hall exit doors 7 and 8 on the South Hall (between Rooms 142 and Harmony Hall) were observed obstructed by an approximate 3 foot wide by 12 foot long and 12" deep hole that had been cut in the floor for construction renovations. This means of egress was one of the two required means of egress for the following spaces: resident rooms 142, 143, 144, 145, 156, 147, 148, 149, 150, soiled utility, pharmacy, Harmony Hall, Rehab/Therapy. There was not a construction barrier or wall separating the hole in the floor from adjacent occupied spaces. During interview with Facility Owner on 03/13/2024 at approximately 10:33 AM, Facility Owner stated the construction project started on June 6, 2023. 2. On 03/12/2024 at approximately 3:15 PM, observation revealed the exit doors 5 and 6 were observed obstructed by several beds and equipment stored in the hall on both sides of the aisle not free from all obstructions to full use in case of emergency. 3. On 03/12/2024 at approximately 3:15 PM,		at 5:00pm, relocated to Rooms 128, 135, 137 with 2 means of egress to exit. The Soiled Utility Room, Pharmacy Room and Rehab/Therapy room were relocated on3/13/2024. Harmony Hall Meeting Room has been moved to The Admissions Office off the Front Lobby on 3/15/2024.3. Immediate action of moving residents to rooms 128, 135 and 137 was taken to ensure the safety of residents, staff and visitors in the event of an emergency. The Soiled Utility Room has been moved down the hall and around the corner, across from room 126. Pharmacy room has been moved to the North Unit Central Supply Room. The Therapy Gym has been moved to the North Unit Activity Room. Harmony Hall Meeting Room has been moved to The Admissions Office off the Front Lobby. Measurable Milestones to correct the Deficiency: 3/13/2024 - Structural Engineering verified structural integrity of construction area. 04/12/24 - Plumbing contractor submitted plumbing permit request to the Battle Creek plumbing inspector for an underground permit for 2 repairs for the current work order and past repairs. 04/22/2024 - All equipment removed from construction area. 05/06/24 - Receive permit approval from Battle Creek Plumbing department. 5/7/24 – Battle Creek Building department to inspect and advise on building permits needed 5/10/24 – Submit requests for necessary building permits to Battle Creek building department 5/20/24 Contractor will cut, process, and remove the tree that has caused a large sag in outside sewer pipe. 5/27/24 - Plumbing contractor will remove and replace damaged piping in room #150. Minor Plumbing repairs including removing/setting	

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	observation revealed the exit door 7 will not open due to the structural damage and the building settling causing an obstruction to use in full for proper exiting. This means of egress has not been maintained free of all obstructions of full use in case of an emergency. During interview at this time, when the door was attempted to be opened by the surveyor, Maintenance Director stated it must be from it settling. On 03/12/2024 from 10:00 AM - 11:03 AM, record review of the annual fire door inspection, dated 11/09/23, revealed "Door #7 does not close properly." When asked if any doors had been repaired, Maintenance Director did not have any evidence of repairs. 4. On 03/12/2024 at approximately 3:15 PM, observation revealed resident beds and wheelchairs in the hall stored next to rooms 143, 145, and 146. These observations were confirmed by interview with Facility Owner, Facility Administrator and Facility Maintenance at the times of observation. The Immediate Jeopardy began on 06/06/2023, when construction began on the south hallway egress path. The Facility Administrator was notified of the Immediate Jeopardy on 03/13/2024 at 11:41 AM. The surveyor confirmed by observation and interview the Immediate Jeopardy was removed on 03/18/2024, but noncompliance remains at pattern, with potential for more than minimal harm that is not Immediate Jeopardy due to construction work that is incomplete and sustained compliance that has not been verified by the State Agency. The Immediate Jeopardy that began on 06/06/2023, was removed on 03/18/2024 when the facility took the following actions to remove		toilets, replacing aging water valves, cut, remove and repair the separated sewer pipe and replace with new PVC and underground rated fittings. Excavate to replace the sagging pipe, stone, and sand to backfill. 5/31/24 - City of Battle Creek inspector will verify plumbing repairs. 6/10/24 - Receive permit approval from Battle Creek building department. 6/17/24 - Foundation repair contractor will use Poly-Level Foam to Lift and Stabilize Flooring in south hall construction area. 6/17/24 – Fire wall contractor to make any fire wall/fire barrier repairs needed. 6/18/24 – Structural engineer to verify integrity of fire barriers/walls. 6/20/24 - Emergency Exit Door repairs will be completed. 6/24/24 - Concrete Company will return to fill Trenches in the hallways with concrete to prepare for new flooring. 6/28/24 - Battle Creek building department inspect foundation and fire wall repairs. 7/8/24- Doors for Rooms #142 146 are repaired and smoke-tight. 7/10/24 - Foundation repair contractor will use Poly-Level Foam to Lift and Stabilize Cracked Flooring in North and south hall areas outside the Courtyards. 7/10/24 – Fire wall contractor to make any firewall/fire barrier repairs needed 7/11/24 - Structural engineer to verify integrity of fire barriers/walls. 7/19/24 - Battle Creek building department to inspect the additional foundation and fire wall repairs. 7/22/24 - Flooring contractor will install new flooring in cracked areas of the facility halls, flooring Adjacent to rooms 101 & 102-North Unit, Flooring adjacent to rooms 121 & 122-South Unit. 8/1/24 - Drywall Company to install and repair	

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	the immediacy: Identification of Residents Affected or Likely to be Affected: 1. This affected 3 residents on the hallway in rooms, 148, 149 and 150. 2. Residents in room 148, 149 and 150 were moved on 3/12/2024 at 5:00pm, relocated to Rooms 128, 135, 137 with 2 means of egress to exit. The Soiled Utility Room, Pharmacy Room and Rehab/Therapy room were relocated on 3/13/2024. Harmony Hall Meeting Room has been moved to The Admissions Office off the Front Lobby on 3/15/2024. 3. Immediate action of moving residents to rooms 128, 135 and 137 was taken to ensure the safety of residents, staff and visitors in the event of an emergency. The Soiled Utility Room has been moved down the hall and around the corner, across from room 126. Pharmacy room has been moved to the North Unit Central Supply Room. The Therapy Gym has been moved to the North Unit Activity Room. Harmony Hall Meeting Room has been moved to The Admissions Office off the Front Lobby 4. The Means of Egress-Corridors and Exits Policy was reviewed and deemed appropriate on 3/13/2024. 5. Working Staff were immediately in serviced on 3/13/2024 on The Construction Area and Means of Egress - Corridors and Exits. Non-working Staff were in serviced by phone and will be on next day of working. Actions to Prevent Occurrence/Recurrence: 6. No access or activity will occur in the areas of		Drywall surfaces on North Unit by rooms 117-120. 9/1/24 - Final building inspections completed by Battle Creek building department. 9/30/24 – Inspection by Bureau of Fire Services for completion of project Increased Fire Safety Measures: Interim Safety Measures: *Fire Drills 2 times monthly each shift for 6 months *Monthly Fire Safety Awareness Training of all staff for 6 months Temporary Waiver Expiration Date is 9/30/2024.	

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 _____	3/18/2024

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	The Soiled Utility Room, Pharmacy Room, Therapy Gym, or Harmony Hall and rooms 142-150.			
K0222 SS= E	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	K0222	K222 The facility is requesting a temporary waiver for this citation. This request for a temporary waiver will not adversely affect the health and safety of residents and staff at the Skilled Nursing Facility. This affected 3 residents on the hallway in rooms, 148, 149 and 150.2. Residents in room 148, 149 and 150 were moved on 3/12/2024 at 5:00pm, relocated to Rooms 128, 135, 137 with 2 means of egress to exit. The Soiled Utility Room, Pharmacy Room and Rehab/Therapy room were relocated on3/13/2024. Harmony Hall Meeting Room has been moved to The Admissions Office off the Front Lobby on 3/15/2024.3. Immediate action of moving residents to rooms 128, 135 and 137 was taken to ensure the safety of residents, staff and visitors in the event of an emergency. The Soiled Utility Room has been moved down the hall and around the corner, across from room 126. Pharmacy room has been moved to the North Unit Central Supply Room. The Therapy Gym has been moved to the North Unit Activity Room. Harmony Hall Meeting Room has been moved to The Admissions Office off the Front Lobby. Measurable Milestones to correct the Deficiency: 6/17/24 Foundation repair contractor will use Poly-Level Foam to lift and Stabilize Flooring in South Hall construction area. 6/20/2024 The Egress-Corridor and Emergency exit door repairs will be completed.	9/1/2024

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	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-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, special needs locking arrangements in accordance with 19.2.2.2.5.2, delayed egress locking in accordance with 19.2.2.2.4, access-controlled egress doors in accordance with 19.2.2.2.4, or elevator lobby exit access in accordance with 19.2.2.2.4. This deficient practice could affect 40 occupants in the event of of a fire emergency. Findings Include: On 03/12/2024 at approximately 3:29 PM, observation revealed the facility failed to maintain the emergency exit door located at the		6/24/2024 Concrete Company will return to fill trenches in the hallways with concrete to prepare for new flooring. Element #1 The Foundation repair contractor will use Poly-Level Foam to Lift and Stabilize Flooring in the South Hall Construction Area. The Emergency Exit Doors will be repaired. The emergency exit door located at the end of South Hall, near room 144 will be functional, and the concrete will be leveled outside the door to allow the door to open completely by 9/1/24. Element #2 This deficient practice has the potential to affect all occupants in the event of an emergency. Element #3 The Means of Egress-Corridors and Exits Policy was reviewed and deemed appropriate by the QAPI Committee on 3/13/2024. Working Staff were immediately in serviced on 3/13/2024 on The Construction Area and Means of Egress - Corridors and Exits. Non-working Staff were in serviced by phone and will be on next day of working. 3/18/2024 by the IDT Team and Managers. Emergency exit door near the end of south hall will be repaired and operable by 9/1/24. Element #4 The Maintenance Director or designee will audit proper means of all egress and exits 3 x weekly for 4 weeks. Results of the audits will be reported to monthly QAPI.	

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	end of South Hall, near room 144. This emergency exit door failed to completely open due to the bottom of the door catching on the concrete when tested. The emergency exit door only opened approximately 20 inches until it stopped. This finding was confirmed by interview with Facility Maintenance at the time of observation.		The Administrator is responsible for maintaining compliance. The Compliance Date is 9/1/2024.	
K0291 SS= F	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 REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure automatic emergency lighting of 1-1/2 hour duration is provided in accordance with 7.9, as required by 19.2.9.1. This deficient practice could affect all occupants in the event of a fire emergency. Findings Include: 1. On 03/12/2024 between the hours of 10:00-11:03 AM, record review revealed the facility failed to provide documentation for the monthly 30 second testing of emergency lighting. No documentation was provided by the exit of the survey. 2. On 03/12/2024 between the hours of 10:00-11:03 AM, record review revealed the facility failed to provide documentation for the annual 90 minute testing of emergency lighting. No documentation was provided by the exit of the survey.	K0291	K291 Element #1 The Monthly 30 second testing of the emergency lighting will be completed by 4/22/2024. The Annual 90-minute testing of the emergency lighting will be completed by 4/22/2024. Element #2 This deficient practice has the potential to affect all occupants in the event of an emergency. Element #3 The Emergency Lighting Policy was reviewed and deemed appropriate by the QAPI Committee on 3/26/2024. The Administrator will reeducate the Maintenance Director on the importance of conducting scheduled testing of the emergency lighting by 4/22/2024. Element #4 The Maintenance Department or designee will audit 3 x weekly for 4 weeks to confirm that the Emergency Lighting is tested as scheduled. Results of the audits will be	4/22/2024

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	These findings were confirmed by interview with Facility Maintenance at the time of record review.		reported to monthly QAPI. The Administrator will be responsible for maintaining compliance. The Compliance Date is 4/22/2024.	
K0321 SS= E	Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by:	K0321	K321 Element #1 Rooms will be cleared by 4/22/24 of storage. Rooms 143 and Room 145 floor will be repaired to be smoke tight with flooring repair within Waivers requested to lift flooring in K Tags 211 which will coincide with repair of room 143 and 145. Element #2 This deficient practice has the potential to affect 20 occupants in the event of an emergency. Element #3 The Hazardous Areas Policy was reviewed and deemed appropriate by the QAPI committee on 3/26/2024. The Administrator will reeducate the Maintenance Director on the importance of ensuring all hazardous areas are equipped with self-closing devices by 4/22/2024. Element #4	4/22/2024

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	Based on observation and interview, the facility failed to provide Hazardous areas protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. This deficient practice could affect 20 occupants in the event of a fire emergency. Findings Include: 1. On 03/12/2024 at approximately 3:13 PM, observation revealed resident room 142 is being used for storage without a self-closing device on the door. 2. On 03/12/2024 at approximately 3:17 PM, observation revealed resident room 143 is being used for storage without a self-closing device on the door. 3. On 03/12/2024 at approximately 3:20 PM, observation revealed resident room 144 is being used for storage without a self-closing device on the door. 4. On 03/12/2024 at approximately 3:38 PM, observation revealed resident room 145 is being used for storage without a self-closing device on the door. 5. On 03/12/2024 at approximately 3:38 PM, observation revealed resident room 146 is being used for storage without a self-closing device on		The Maintenance Department or designee will audit 3 x weekly for 4 weeks to verify that all hazardous areas have self-closing devices. Results of the audits will be reported to QAPI The Administrator will be responsible for maintaining compliance. The Compliance Date is 4/22/2024.	

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	the door. These findings were confirmed by interview with Facility Maintenance at the time of observation.			
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 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, unless meeting the requirements of 19.3.2.5.2, 19.3.2.5.3 or 19.3.2.4.4, as required by 19.3.2.5.1 through 19.3.2.5.5, 9.2.3 and TIA 12-2. This deficient practice could affect all occupants in the event of a fire emergency. Findings Include:	K0324	K324 Element #1 The Semi-Annual Hood cleaning will be completed by 4/22/2024. The Kitchen hood suppression semi-annual service will be completed by 4/22/2024. Element #2 This deficient practice has the potential to affect all occupants in the event of an emergency. Element #3 The Hood Suppression and Cleaning Policy was reviewed and deemed appropriate by the QAPI committee on 3/28/2024. The Administrator will reeducate the Maintenance Director on the importance of ensuring all hood cleanings and inspection are completed semi-annually by 4/22/2024. Element #4 The Maintenance Department or designee will audit monthly to verify that all semi-annual hood cleanings and inspections are completed semiannually. Results of the audits will be reported to monthly QAPI The Administrator will be responsible for maintaining compliance. The Compliance Date is 4/22/2024.	4/22/2024

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	1. On 03/12/2024 between the hours of 10:00-11:03 AM, record review revealed the kitchen hood suppression semi-annual service was conducted in January 2023 and the next service was due in July of 2023. That semi-annual service was conducted in November 2023, this being past due for the required semi-annual service by approximately 4 months. 2. On 03/12/2024 between the hours of 10:00-11:03 AM, record review revealed the facility failed to provide documentation for the current semi-annual hood cleaning. The last hood cleaning service documentation provided was 01/05/2023. These findings were confirmed by interview with Facility Maintenance at the time of record review.			

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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 record review 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: On 03/12/2024 between the hours of 10:00-11:03 AM, record review revealed the facility failed to provide documentation for the contents, furnishings and upholstered furniture flame spread criteria as required by NFPA 101 2012 edition, 10.3.1, 10.3.2.1 and 10.3.3. No documentation of the flame spread requirement was provided by survey exit. This finding was confirmed by interview with Facility Maintenance at the time of record review.	K0331	K331 Element #1 The facility will create a flame spread binder with documentation on the contents, furnishings and upholstered furniture flame spread criteria as required by NFPA 101 2012 edition, 10.3.1, 10.3.2.1 and 10.3.3 by 4/22/2024. Element #2 This deficient practice has the potential to affect all occupants in the event of an emergency. Element #3 The flame spread policy was reviewed and deemed appropriate by the QAPI committee on 3/26/2024. The Administrator will reeducate the Maintenance Director on the importance of ensuring 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 by 4/22/2024. Element #4 The Maintenance Department or designee will audit 3 x weekly for 4 weeks to ensure flame spread documentation is in place. Results of the audits will be reported to monthly QAPI. The Administrator is responsible for maintaining compliance. The Compliance Date is 4/22/2024.	4/22/2024

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K0342 SS= F	Fire Alarm System - Initiation Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure manual initiation of the fire alarm system is arranged as required by 19.3.4.2.1, 19.3.4.2.2 and 9.6.2.5. This deficient practice could affect all occupants in the event of a fire emergency. Findings Include: On 03/12/2024 at approximately 3:15 PM, observation revealed the smoke detector in the middle of the corridor, between rooms 143 and 145, was covered with a plastic bag taped over it. This finding was confirmed by interview with Facility Maintenance at the time of observation.	K0342	K342 Element #1 The plastic bag was removed from the smoke detector between rooms 143 and 145 on 3/28/2024. A facility wide audit of all smoke detectors will be conducted to ensure all detectors are free from being covered by 4/22/2024. Element #2 This deficient practice has the potential to affect all occupants in the event of an emergency. Element #3 The Fire Alarm Policy was reviewed and deemed appropriate by the QAPI committee on 3/26/2024. The Administrator will reeducate the Maintenance Director on the importance of ensuring manual initiation of the fire alarm system is arranged as required by 19.3.4.2.1,19.3.4.2.2 and 9.6.2.5 by 4/22/2024. Element #4 The Maintenance Department or designee will audit 3 x weekly for 3 months to ensure manual initiation of the Fire Alarm System occurs. Results of the audits will be reported to monthly QAPI. The Administrator is responsible for maintaining compliance. The Compliance Date is 4/22/2024.	4/22/2024

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K0344 SS= F	Fire Alarm - Control Functions Fire Alarm - Control Functions The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 18.3.4.4, 19.3.4.4, 9.6.1, 9.6.5, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the fire alarm automatically activates required control functions, and is provided with an alternative power supply in accordance with NFPA 72, as required by 19.3.4.4, 9.6.1 and 9.6.5. This deficient practice could affect all occupants in the event of a fire emergency. Findings Include: On, 03/12/2024 at approximately 12:00 PM, observation revealed the fire alarm system has an active trouble mode on the system. This finding was confirmed by interview with Facility Maintenance at the time of observation.	K0344	K344 Pinnacle Care of Battle Creek is requesting a Temporary Waiver for this Citation CMS Justification: This request for Temporary Waiver will not adversely affect the health and safety of residents and staff at the Skilled Nursing Facility. Measurable Milestones to correct the Deficiency: Work Completed by 8/15/2024: Scope of Work: Fire Alarm Cellular Dialer Replacement for Monitoring *4/29/24 – Drawings were complete and submitted to the Bureau of Fire Safety for Plan Review. The Submittal number is PR2024BFS-002213. *An Electrical permit with the City of Battle Creek is in process. The contractor's registration with them had to be updated in their system before a permit application could be submitted. *5/9/24 - Tech from company will be on site to trouble shoot unknown event alert. *5/31/24 - Permit approval from the City of Battle Creek *6/28/24 - Plan approval from BFS *7/15/24 - Fire Alarm Cellular Dialer Replacement - The timeline for the work to be completed is dependent upon plan review completion and approval from the Bureau of Fire Services and permit issuance of the City of Battle Creek. Once these items are approved, the work can be scheduled and completed. The expected start date after approval would be one to two weeks due to our scheduling time frame. The work once started should take one workday unless there are unforeseen issues.	8/15/2024

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	134140	A. BUILDING _____ B. WING _____	**3/18/2024**

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			*8/15/24 - All inspections are to be completed once work is completed. The timeframe for inspections is based on the availability of the local and state inspectors' schedules. Increased Fire Safety Measures: Interim Safety Measures: *Fire Watch until dialer is replaced *Fire Drills 2 times monthly each shift for 2 months *Monthly Fire Safety Awareness Training of all staff for 6 months Temporary Waiver Expiration Date is 8/15/2024. Element #1 Fire Alarm Cellular Dialer Replacement for Monitoring by 8/15/24. The active trouble mode was corrected on 5/2/24 and is currently functioning properly. Element #2 This deficient practice has the potential to affect all occupants in the event of an emergency. Element #3 The Fire Alarm Policy was reviewed and deemed appropriate by the QAPI committee on 3/26/2024. The Administrator will reeducate the Maintenance Director on the importance of the Fire Alarm automatically activating required control functions, and is provided with an alternative power supply in accordance with NFPA 72, as required by19.3.4.4, 9.6.1 and 9.6.5 by 4/22/2024. Element #4	

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			The Maintenance Department or designee will conduct audits 3 x weekly for 3 months, then quarterly. Results of the audits will be reported to monthly QAPI. The Administrator is responsible for maintaining compliance. The facility will be in compliance by 8/15/24.	
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 record review 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, and records are readily available as required by 19.6.1.3, 9.6.1.5, NFPA 70 and NFPA 72. This deficient practice could affect all occupants in the event of a fire emergency. Findings Include: 1. On 03/12/2024 between the hours of 10:00-11:03 AM, record review revealed a noted	K0345	K345 Element #1 The Fire Alarm Technician from company came out for trouble shooting and resolved the system trouble event on the panel on 5/2/24. The system is now operating normally. Element #2 This deficient practice has the potential to affect all occupants in the event of an emergency. Element #3 The Fire Alarm Policy was reviewed and deemed appropriate by the QAPI committee on 3/26/2024. The Administrator will reeducate the Maintenance Director on the importance of the Fire Alarm automatically activating required control functions, and is provided with an alternative power supply in accordance with NFPA 72, as required by19.3.4.4, 9.6.1 and 9.6.5 by 4/22/2024. Element #4	5/2/2024

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	deficiency on the annual fire alarm inspection report dated 11/16/23. Deficiency noted "No communication with laundry head. Only received trouble-not alarm." During interview with Facility Maintenance at this time, when asked if they had corrected the deficiency noted, Facility Maintenance stated "they were supposed to be out." No proof was provided of the noted deficiency being corrected. 2. On 03/12/2024 between the hours of 10:00-11:03 AM, record review revealed the facility failed to provide documentation of the Quarterly Dialer Test. No documentation was provided by the exit of the survey. These findings were confirmed by interview with Facility Maintenance at the time of record review.		The Maintenance Department or designee will conduct audits 3 x weekly for 3 months, then quarterly. Results of the audits will be reported to monthly QAPI. The Administrator is responsible for maintaining compliance. The facility will be in compliance by 5/2/24.	
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 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:	K0353	K353 Element #1 The 5-year internal inspection of piping for the sprinkler system will be completed by 4/22/2024 The 5-year inspection of the check valve for the sprinkler system will be completed by 4/22/2024. The sprinkler inspection flow test will be completed by 4/22/2024. Element #2 This deficient practice has the potential to affect all occupants in the event of an emergency. Element #3 The Sprinkler System Policy was reviewed	4/22/2024

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	Based on record review and interview, the facility failed to ensure the automatic sprinkler and standpipe systems are inspected, tested and maintained in accordance with NFPA 25, and records are readily available as required by 9.7.5, 9.7.7, 9.7.8 and NFPA 25. This deficient practice could affect all occupants in the event of a fire emergency. Findings Include: 1. On 03/12/2024 between the hours of 10:00-11:03 AM, record review revealed the facility failed to provide documentation of the 5-year internal inspection of piping for the sprinkler system as required in NFPA 25. No documents were provided for review by the exit of the survey. 2. On 03/12/2024 between the hours of 10:00-11:03 AM, record review revealed the facility failed to provide documentation of the 5-year inspection of the check valve for the sprinkler system as required in NFPA 25. No documents were provided for review by the exit of the survey. 3. On 03/12/2024 between the hours of 10:00-11:03 AM, record review revealed the facility failed to provide documentation for first, second, third and fourth quarter automatic sprinkler inspection flow test. No documents were provided for review by the exit of the survey. These findings were confirmed by interview with Facility Maintenance at the time of record review.		and deemed appropriate by the QAPI committee on 3/26/2024. The Administrator will reeducate the Maintenance Director on the importance of ensuring the automatic sprinkler and standpipe systems are inspected, tested and maintained in accordance with NFPA 25, and records are readily available as required by 9.7.5, 9.7.7, 9.7.8 and NFPA 25. By 4/22/2024. Element #4 The Maintenance Department or designee will audit of the sprinkler system testing documentation once a month, for 3 months, and then quarterly. Results of the audits will be reported to monthly QAPI. The Administrator is responsible for maintaining compliance. The Compliance Date is 4/22/2024.	
K0363 SS= F	Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings,	K0363	K363 Element #1	4/22/2024

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	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 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		The door coordinator on cross-corridor doors #14 will be installed by 4/22/2024. The central supply room #107 door handle penetration will be repaired by 4/22/2024. The janitors closet door #24 penetration gap above the door handle was repaired by 4/22/2024. Cross-corridor doors 19 and 20 will be repaired by 4/22/2024. The gap above cross-corridor doors 19 and 20 will be repaired by 4/22/2024. A facility wide door audit will be conducted for any other door repairs. Any additional doors requiring repairs will be repaired by 4/22/2024. Element #2 This deficient practice has the potential to affect all occupants in the event of an emergency. Element #3 The Facility Door Policy was reviewed and deemed appropriate by the QAPI committee on 3/26/2024. The Administrator will reeducate the Maintenance Director on the importance of doors protecting corridor openings in other than required enclosures of vertical openings, exits or hazardous areas are 13/4 inch solid-bonded core wood or capable of resisting the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed as required by 19.3.6.3, and 42CFR 403, 418, 460, 482, 483 and 485 by 4/22/2024. Element #4 The Maintenance Department or designee will audit 3 x weekly for 4 weeks for corridor door,	

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	openings in other than required enclosures of vertical openings, exits or hazardous areas are 1 3/4 inch solid-bonded core wood or capable of resisting the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed as required by 19.3.6.3, and 42 CFR 403, 418, 460, 482, 483 and 485. There is no impediment to the closing of doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. 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. This deficient practice could affect all occupants in the event of a fire emergency. Findings Include: 1. On 03/12/2024 at approximately 2:24 PM, observation revealed the facility failed to maintain cross-corridor door #14 at the North Hall. The cross-corridor door failed to close to a smoke tight fit when tested. Door Coordinator did not operate correctly when tested. 2. On 03/12/2024 at approximately 2:27 PM, observation revealed the corridor door for central supply room #107 had a penetration at the door		then quarterly, for 2 quarters. Results of the audits will be reported to monthly QAPI. The Administrator is responsible for maintaining compliance. The Compliance Date is 4/22/2024.	

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	handle approximately ¼" through the door. 3. On 03/12/2024 at approximately 2:34 PM, observation revealed the janitors closet door #24 has a penetration gap above the door handle. 4. On 03/12/2024 at approximately 2:43 PM, observation revealed the facility failed to maintain cross-corridor doors 19 and 20. Both doors failed to close when tested. The floor was observed catching the bottom of the door preventing them from closing to a smoke tight fit when tested. 5. On 03/12/2024 at approximately 2:48 PM, observation revealed the facility failed to maintain cross-corridor doors 19 and 20. A 3/8" gap was observed above door 19, at the top of the frame and the wall of smoke barrier noted on the smoke barrier map. These findings were confirmed by interview with Facility Maintenance at the time of observation.			

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K0371 SS= F	Subdivision of Building Spaces - Smoke Compar Subdivision of Building Spaces - Smoke Compartments 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 Detail in REMARKS zone dimensions including length of zones and dead-end corridors. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure smoke barriers were provided to form at least 2 smoke compartments on every floor as required by 19.3.7.1 and 19.3.7.2. This deficient practice could affect all occupants in the event of a fire emergency. Findings Include: On 03/12/2024 between the hours of 10:00-11:03 AM, record review revealed the facility failed to provide a smoke barrier map that shows the facility compartmentalized by smoke barriers. All smoke barriers shown on the map provided do not show complete compartmentalization from one smoke compartment to another throughout the facility. This finding was confirmed by interview with Facility Maintenance at the time of record review.	K0371	K371 Element #1 The smoke barrier map was updated and verified on 3/28/2024. Element #2 This deficient practice has the potential to affect all occupants in the event of an emergency. Element #3 The Smoke Barrier/Compartments Policy was reviewed and deemed appropriate by the QAPI committee on 3/26/2024. The Administrator will reeducate the Maintenance Director on ensuring smoke barriers are provided to form at least 2 smoke compartments on every floor as required by 19.3.7.1 and19.3.7.2 by 4/22/2024. Element #4 The Maintenance Department or designee will conduct weekly audits of the smoke barrier documentation, for 3 months, and then quarterly, for 2 quarters. Results of the audits will be reported to monthly QAPI. The Administrator is responsible for maintaining compliance. The Compliance Date is 4/22/2024.	4/22/2024

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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, as required by 19.5.1.1, 9.1.1 and 9.1.2. This deficient practice could affect 45 occupants in the event of an unauthorized exposure to exposed wires. Findings Include: On 03/12/2024 at approximately 2:59 PM, an electrical outlet on South hall, just past cross-corridor doors 11 and 12, was observed not secured to the wall, exposing wires to residents, staff and visitors. This finding was confirmed by interview with Facility Maintenance at the time of observation.	K0511	K511 Element #1 Electrical outlet on south hall was repaired on 4/1/2024. A Facility wide audit of all outlets will be conducted to ensure outlets are in working order, any outlets found to not work will be repaired by 4/22/2024. Element #2 This deficient practice has the potential to affect 45 occupants in the event of an emergency. Element #3 The Electrical Policy/Outlets was reviewed and deemed appropriate by the QAPI committee on 3/26/2024. The Administrator will reeducate the Maintenance Director on ensuring equipment using gas or gas-related piping complies with NFPA 54, and electrical wiring and equipment complies with NFPA 70, as required by 19.5.1.1, 9.1.1 and9.1.2. by 4/22/2024. Element #4 The Maintenance Department or designee will conduct random 3 x weekly for 4 weeks of the electrical outlets on south hall, then quarterly, for 2 quarters. The results of the audits will be reported to monthly QAPI. The Administrator is responsible for maintaining compliance. he Compliance Date is 4/22/2024.	4/22/2024

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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, and installed in accordance with the manufacturer's specifications as required by 19.5.2.1 and 9.2. This deficient practice could affect all occupants in the event of a fire emergency. Findings Include: On 03/12/2024 between the hours of 10:00-11:03 AM, record review revealed the facility failed to provide documentation for the 4-year damper inspection throughout the facility. No documentation was provided by the exit of the survey. This finding was confirmed by interview with Facility Maintenance at the time of record review.	K0521	K521 Element #1 The 4-year damper inspection will be completed by 4/22/2024. Element #2 This deficient practice has the potential to affect 45 occupants in the event of an emergency. Element #3 The HVAC Policy was reviewed and deemed appropriate by the QAPI committee on 3/26/24. The Administrator will reeducate the Maintenance Director on ensuring heating, ventilation and air conditioning is in compliance with 9.2, and installed in accordance with the manufacturer's specifications as required by 19.5.2.1 and 9.2. by 4/22/2024. Element #4 The Maintenance Department or designee will audit monthly for damper maintenance documentation once a month, for 3 months, and then quarterly, for 2 quarters. Results of the audits will be reported to monthly QAPI. The Administrator is responsible for maintaining compliance. The Compliance date is 4/22/2024.	4/22/2024

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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 ensure fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions, are held at unexpected times under varying circumstances, conducted at least quarterly on each shift and responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership as required by 19.7.1.4 through 19.7.1.7. This deficient practice could affect all occupants in the event of a fire emergency. Findings Include: On 03/12/2024 between the hours of 10:00-11:03 AM, record review revealed the facility failed to provide the fire drills records for 1st quarter- 2nd shift, 2nd quarter- 1st, 2nd, and 3rd shift, 3rd quarter- 1st, 2nd and 3rd shift, and 4th quarter- 2nd and 3rd shift. No documentation was provided for any of the missing fire drills noted. This finding was confirmed by interview with Facility Maintenance at the time of record review.	K0712	K712 Element #1 A Binder was created for documentation of Fire Drills. Fire Drills were conducted by the Maintenance Director on Day Shift and Night Shift at 2:40PM and 7:21 PM on March 21, 2024. Element #2 The facility has determined that all residents have the potential to be affected by the deficient practice. Element #3 The Fire Drill Policy was reviewed and deemed appropriated by the QAPI Committee. The Administrator reeducated the Maintenance Director on the expectation of maintaining proper documentation of Fire Drills on 3/21/24. Element #4 The Maintenance Department or designee will conduct monthly audits for Fire Drill documentation monthly for 4 months. The results of the audits will be brought to monthly QAPI. The Administrator is responsible for maintaining compliance. The Compliance Date is 4/22/2024.	4/22/2024
	Maintenance, Inspection & Testing - Doors	K0761	K761	4/22/2024

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K0761 SS= D	Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to inspect and test annually in accordance with NFPA 101, 19.7.6, 8.3.3.1 and NFPA 80, Standard for Fire Doors and Other Opening Protectives 5.2, 5.2.3. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. This deficiant practice could affect all occupants in the event of a fire emergency. Findings Include: On 03/12/2024 between the hours of 10:00-11:03 AM, record review revealed multiple deficiencies on the annual fire door inspection report from an outside vendor dated 11/09/23. The fire door map and deficiency report show Door #7, door #8,		Element #1 Deficiencies for doors #7,8,11,12,14,19,20,21, and 24 will be repaired by 4/22/2024. Element #2 This deficient practice has the potential to affect all occupants in the event of an emergency. Element #3 The Fire Door Policy was reviewed and deemed appropriate by the QAPI committee on 3/26/2024. The Administrator will reeducate the Maintenance Director on ensuring that corrected deficiencies are documented on each door that was noted and the Fire Door Policy by 4/22/2024. Element #4 The Maintenance Director or designee will audit the Fire Doors 3 x weekly for 3 months, and then quarterly, for 2 quarters. Results of the audits will be reported to monthly QAPI. The Administrator is responsible for maintaining compliance. The Compliance Date is 4/22/2024.	

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	door #11, door #12, door #14, door #19, door #20, door #21, and door #24 all have deficiencies. No corrected documentation on each door was noted. This finding was confirmed by interview with Facility Maintenance at the time of record review.			
K0781 SS= F	Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure portable space heating devices shall be prohibited in all health care occupancies. Unless used in non-sleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit as required by 18.7.8, 19.7.8. This deficient practice could affect all occupants in the event of a fire emergency. Findings Include: 1. On 03/12/2024 at approximately 11:04 AM, observation revealed two space heaters located in the maintenance office. 2. On 03/12/2024 at approximately 2:01 AM, observation revealed a space heater located in the dietary office. This space heater was plugged into a power strip cord. 3. On 03/12/2024 at approximately 2:29 AM,	K0781	K781 Element #1 Space heaters were removed from maintenance, dietary, and activity offices on 3/13/2024. Element #2 This deficient practice has the potential to affect all occupants in the event of an emergency. Element #3 The Space Heater Policy was reviewed and deemed appropriate by the QAPI committee on 3/26/2024. The Administrator will reeducate the Maintenance Director, Activity Director and Dietary Manager on ensuring portable space heating devices shall be prohibited in all health care occupancies. Unless used in non-sleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit as required by 18.7.8, 19.7.8. by 4/22/2024. Element #4 The Maintenance Department or Designee will audit 3 x weekly for 3 months, and then quarterly, for 2 quarters. Results of the audits will be reported to monthly QAPI.	4/22/2024

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	observation revealed the facility had a space heater located in the activity's office. This space heater was plugged into a power strip cord. Record review revealed the facility policy prohibits space heaters in the facility at any time. Facility portable space heater policy states: "It is the policy of this facility not to use space heaters." These findings were confirmed by interview with Facility Maintenance at the time of observation and record review.		The Administrator will be responsible for sustained compliance. The Compliance Date is 4/22/2024.	
K0914 SS= F	Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K0914	K914 Element #1 Annual receptacle testing for non-listed hospital-grade receptacles will be completed by 4/22/2024. Element #2 This deficient practice has the potential to affect all occupants in the event of an emergency. Element #3 The facility electrical systems policy was reviewed and deemed appropriate by the QAPI committee on 3/26/2024. The Administrator will reeducate the Maintenance Director on ensuring hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing by 4/22/2024.	4/22/2024

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	Based on record review and interview, the facility failed to ensure hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance date. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Records are maintained of required tests and associated repairs or modifications, contain date, room or area tested and results as required by 6.3.4 of NFPA 99. This deficient practice could affect all occupants in the event of a fire emergency. Findings Include: On 03/12/2024 between the hours of 10:00-11:03 AM, record review revealed the facility failed to provide documentation of annual receptacle testing for non-listed hospital-grade receptacles. No documentation was provided by exit of the survey. This finding was confirmed by interview with Facility Maintenance at the time of record review.		Element #4 The Maintenance Director or Designee will audit 3 x weekly for 3 months, and then quarterly, for 2 quarters to ensure receptacle testing for non-listed hospital grade receptacles. Results of the audits will be reported to monthly QAPI. The Administrator is responsible for maintaining compliance. The Compliance Date is 4/22/2024.	
K0918 SS= F	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	K0918	K918 Element #1 Annual generator service will be completed by 4/22/2024. Monthly generator load test will be completed by 4/22/2024. Weekly generator inspections will be completed by 4/22/2024. Monthly specific gravity test will be completed by 4/22/2024. Generator fuel quality test will be completed	4/22/2024

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	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 observation, record review and interview, the facility failed to ensure generators or other alternative power sources and associated equipment is capable of supplying service within 10 seconds, is maintained, inspected, tested and exercised in accordance with NFPA 110, and records are readily available as required by 6.4.4, 6.5.4 and 6.6.4 of NFPA 99, NFPA 110, NFPA 111 and 700.10 of NFPA 70. This deficient practice could affect all occupants in the event of a power outage or generator failure. Findings Include: 1. On 03/12/2024 between the hours of 10:00-		by 4/22/2024. Annual load bank test will be completed by 4/22/2024. Auxiliary fault was cleared and generator is in normal status by 4/22/2024. Generator fuel was filled and is not signaling low fuel by 4/22/2024. Element #2 This deficient practice has the potential to affect all occupants in the event of an power outage or generator failure. Element #3 The Generator Policy was reviewed and deemed appropriate by the QAPI committee on 3/26/2024. The Administrator will reeducate the Maintenance Director on ensuring generators or other alternative power sources and associated equipment is capable of supplying service within 10 seconds, is maintained, inspected, tested and exercised in accordance with NFPA 110, and records are readily available as required by 6.4.4, 6.5.4 and 6.6.4 of NFPA 99, NFPA 110, NFPA 111 and 700.10 of NFPA 70 by 4/22/2024. Element #4 The Maintenance Department or Designee will conduct random monthly audits of generator and fuel testing documentation once a month, for 3 months, and then quarterly, for 2 quarters. Results of the audits will be reported to monthly QAPI. The Administrator is responsible for maintaining compliance. he Compliance Date is 4/22/2024.	

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	11:03 AM, record review revealed the facility failed to provide current documentation for the annual generator service. No current or previous documentation for the annual generator service was provided by the exit of the survey. 2. On 03/12/2024 between the hours of 10:00-11:03 AM, record review revealed the facility failed to provide documentation for the December 2023 through March 2024, monthly generator load test. Last documented monthly load test was November 8, 2023. No documentation for the missing monthly inspection was provided by the exit of the survey. 3. On 03/12/2024 between the hours of 10:00-11:03 AM, record review revealed the facility failed to record the weekly emergency generator inspections. No documentation for the missing weekly inspections was provided by the exit of the survey. 4. On 03/12/2024 between the hours of 10:00-11:03 AM, record review revealed the facility failed to record the monthly specific gravity test values of the lead-acid generator batteries or the values for the monthly conductance test of the maintenance free generator batteries. 5. On 03/12/2024 between the hours of 10:00-11:03 AM, record review revealed the facility failed to provide documentation a fuel quality test has been performed during the last 12 months, per NFPA 110, 8.3.8, fuel quality test performed at least annually using tests approved by ASTM standards. 6. On 03/12/2024 between the hours of 10:00-11:03 AM, record review revealed the facility failed to record the annual load bank test of the emergency generator as required.			

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	7. On 03/12/2024 at approximately 11:34 AM, observation revealed the generator panel warning light is in trouble supervisory mode signaling Auxiliary Fault. 8. On 03/12/2024 at approximately 11:34 AM, observation revealed the generator panel warning light is in trouble supervisory mode signaling Low Fuel. These findings were confirmed by interview with Facility Maintenance at the time of observation and record review.			
K0920 SS= F	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 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	K0920	K920 Element #1 Extension cords were removed from the maintenance office on 3/13/2024. Refrigerators, coffee pots, and microwaves in offices are no longer plugged into power strips as of 3/13/2024. A facility wide audit will be conducted of offices by 4/22/2024 for electrical equipment/appliances plugged into power strips. Any equipment found plugged into power strips will be removed. Element #2 This deficient practice has the potential to affect all occupants in the event of an emergency. Element #3 The Extension Cords/Power Strip Policy was reviewed and deemed appropriate by the QAPI committee on 3/26/2024. The Administrator will reeducate the Maintenance Director on ensuring power strips are listed for	4/22/2024

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	evidenced by: Based on observation and interview, the facility failed to ensure power strips are listed for the area in which they are used as required by 10.2.3.6 of NFPA 99, 400-8 of NFPA 70 and TIA 12-5, and extension cords are placed in use only temporarily as required by 10.2.4 of NFPA 99 and 590.3(D) of NFPA 70. This deficient practice could affect all occupants in the event of a fire emergency. Findings Include: 1. On 03/12/2024 at approximately 11:07 AM, observation revealed an extension cord plugged into a power strip cord, plugged into another power strip cord with a refrigerator plugged into the last power strip cord, in the maintenance office. 2. On 03/12/2024 at approximately 2:57 PM, observation revealed a refrigerator, coffee pot and microwave plugged into a power strip cord in the therapy office. These findings were confirmed by interview with Facility Maintenance at the time of observation.		the area in which they are used as required by10.2.3.6 of NFPA 99, 400-8 of NFPA 70 and TIA12-5, and extension cords are placed in use only temporarily as required by 10.2.4 of NFPA 99and 590.3(D) of NFPA 70 by 4/22/2024. Element #4 The Maintenance Department or designee will conduct audits 3 x weekly for 3 months, and then quarterly, for 2 quarters. The Administrator is responsible for maintaining compliance. The Compliance Date is 4/22/2024.	