STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	238510	A. BUILDING _____ B. WING _____	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EATON COUNTY MEDICAL CARE FACI	530 W BEECH ST CHARLOTTE, MI 48813

(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 December 18, 2024, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey Eaton County Medical Care Facility was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		
K0000 SS=	INITIAL COMMENTS On December 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, Eaton County Medical Care Facility 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 single story building of type II (111) construction, built in 1966. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 142 certified beds. At the time of the survey the census was 127.	K0000		
K0222 SS= F	Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires	K0222	K222 ELEMENT I: the facility failed to ensure doors in a required means of egress are not	1/27/2025

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

Electronically Signed | 01/17/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in		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 all occupants in the event of a fire emergency. The facility will remove the key pad securing the front entrance/exit at the receptionist desk. The facility will also place 15 second delay mag locks on doors on 400 hall. ELEMENT II: Egress doors will be placed on monthly checks by maintenance to ensure proper operation and documented on a log. ELEMENT III: The Building Services Director or designee will be responsible for auditing compliance with the monthly checks log. The Building Services Director is responsible for ensuring substantial compliance and will review audit findings during QAPI meetings with the Administrator. ELEMENT IV: The facility will be in compliance by 1.27.25	

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	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 all occupants in the event of a fire emergency. Findings Include: 1. On 12/18/2024, at approximately 11:47 AM, observation revealed the front entrance/exit at the receptionist desk required special knowledge to exit the facility. 2. On 12/18/2024 at approximately 3:00 PM, observation revealed the emergency exit to the outside courtyard at the entrance of 400 Hall was mag locked against egress and needed special knowledge to exit the facility.			

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	3. On 12/18/2024 at approximately 3:06 PM, observation revealed the emergency exit to the outside courtyard near resident room 418 in 400 Hall was mag locked against egress and needed special knowledge to exit the facility. These findings were confirmed by interview with Facility Maintenance at the time of the observations.			

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K0232 SS= F	Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the width of aisles or corridors was maintained clear and unobstructed in accordance with 19.2.3.4 and 19.2.3.5. This deficient practice could affect all occupants in the event of in the event of a fire emergency. Findings Include: On 12/18/2024 between the hours of 11:35 AM to 4:05 PM, observation revealed several trash receptacles stored on both sides of the residents corridors without wheels throughout the facility from 100 hall through 600 hall. The only wheeled items that are permitted on one side of the corridor as long all the following are met: a) Equipment in use and carts in use b) Medical Emergency equipment not in use c) Patient lift and transport equipment These findings were confirmed by interview with Facility Maintenance at the time of observation.	K0232	K232 ELEMENT I: The facility failed to ensure the width of aisles or corridors was maintained clear and unobstructed in accordance with 19.2.3.4 and 19.2.3.5. This deficient practice could affect all occupants in the event of in the event of a fire emergency. The facility will remove all non-wheeled Trash containers from halls/corridors. ELEMENT II: The Building Services Director or designee will monitor the halls on a monthly basis to ensure compliance. Findings will be placed on a log. Staff will be educated regarding to ensure the width of aisles or corridors are maintained clear and unobstructed. ELEMENT III: The Building Services Director or designee will complete an audit of the monthly compliance logs and report any noncompliance findings to the Administrator and during QAPI to ensure ongoing compliance. The Building Services Director is responsible for ensuring sustained compliance. ELEMENT IV: The facility will be in compliance by 1.27.25	1/27/2025

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K0251 SS= F	Dead-End Corridors and Common Path of Travel Dead-End Corridors and Common Path of Travel 2012 EXISTING Dead-end corridors shall not exceed 30 feet. Existing dead-end corridors greater than 30 feet shall be permitted to be continued to be used if it is impractical and unfeasible to alter them. 19.2.5.2 This REQUIREMENT is not met as evidenced by: Based upon observation and interview, the facility failed to ensure that dead-end corridors do not exceed 30 feet unless it is impractical or unfeasible to alter them as required by 19.2.5.2. This deficient practice could affect all occupants in the event of a fire emergency. Findings Include: On 12/18/2024 at approximately 12:37 PM, observation revealed the cross-corridor doors located in the pine hall leading out to the service hall are mag locked creating a dead-end corridor greater than 30 ft. These mag locks can only be opened with special knowledge key code or badge to unlock these cross-corridor doors. This finding was confirmed by interview with Facility Maintenance at the time of observation.	K0251	K251 ELEMENT I: The facility failed to ensure that dead-end corridors do not exceed 30 feet unless it is impractical or unfeasible to alter them as required by 19.2.5.2. This deficient practice could affect all occupants in the event of a fire emergency. The Facility will remove key pad securing the door at the end of the 100 hall. ELEMENT II: The doors at the end of the 100 hall will be placed on monthly checks by maintenance to ensure the doors are not secured and documented on a log. ELEMENT III: The Building Services Director or designee will complete an audit of the monthly compliance logs and report any noncompliance findings to the Administrator and during QAPI to ensure ongoing compliance. The Building Services Director is responsible for ensuring sustained compliance. ELEMENT IV: The facility will be in compliance by 1.27.25	1/27/2025

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K0300 SS= E	Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure proper storage of combustible storage, as required by 18.3 and 19.3. This deficient practice could affect 40 occupants in the event of a fire emergency. Findings Include: On 12/18/2024 at approximately 12:33 PM, observation revealed over 50 activity puzzles stored in totes and on the floor of the corridor in residents 100 hall. This deficient practice adds unnecessary combustible fire load and smoke development to a fire in the event of a fire emergency. This finding was confirmed by interview with Facility Maintenance at the time of observation.	K0300	K300 ELEMENT I: The facility failed to ensure proper storage of combustible storage, as required by 18.3 and 19.3. This deficient practice could affect 40 occupants in the event of a fire emergency. The Facility immediately removed the stored puzzles from the 100 hall corridor and will ensure that puzzles will not be stored in totes and/or on the floor of any other corridors. ELEMENT II: The Building Services Director or designee will monitor the corridors to ensure that puzzles are not stored in totes and/or on the floor on a monthly basis to ensure compliance. Findings will be placed on a log. Activities staff will be educated regarding the proper storage of activity items. ELEMENT III: The Building Services Director or designee will complete an audit of the monthly compliance logs and report any noncompliance findings to the Administrator and during QAPI to ensure ongoing compliance. The Building Services Director is responsible for ensuring sustained compliance ELEMENT IV: The facility will be in compliance by 1.17.25	1/27/2025

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K0379 SS= E	Smoke Barrier Door Glazing Smoke Barrier Door Glazing 2012 EXISTING Openings in smoke barrier doors shall be fire-rated glazing or wired glass panels in steel frames. 19.3.7.6, 19.3.7.6.2, 8.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure openings in smoke barrier doors were fire-rated glazing or wired glass panels in steel frames as required by NFPA 7.1.10.2, 19.3.7.6, 19.3.7.6.2 and 8.5. This deficient practice could affect 30 occupants in the event of a fire emergency. Findings Include: 1. On 12/18/2024 at approximately 12:54 PM, observation revealed the cross corridor door vision panel are covered obstructing clear vision in and out of the 600 Hall. This cross corridor door vision panel was located in the 600 Hall near resident room 604. 2. On 12/18/2024 at approximately 1:08 PM, observation revealed the cross corridor door vision panels are covered on the inside of the door and had foam type insulation stuffed between the vision panels and the cover. These cross corridor door vision panels are located in the 600 Hall between the nursing station and office #8. These deficient practices obstruct a clear vision in and out of the halls and does not meet the fire-rated glazing required. These findings were confirmed by interview with Facility Maintenance at the time of the observations.	K0379	K379 ELEMENT I: The facility failed to ensure openings in smoke barrier doors were fire-rated glazing or wired glass panels in steel frames as required by NFPA 7.1.10.2, 19.3.7.6, 19.3.7.6.2 and 8.5. The facility removed the mural covering the cross corridor door vision panels obstructing clear vision in and out of the 600 Hall (Memory Care Neighborhood) near resident room 604 and from the cross corridor door vision panels located in the 600 Hall between the nursing station and office #8. The foam insulation stuffed between the vision panels and the cover were removed as well. ELEMENT II: The cross corridor doors on 600 Hall will be placed on monthly checks by maintenance to ensure vision panels are not obstructed and documented on a log. ELEMENT III: The Building Services Director or designee will complete an audit of the monthly compliance logs and report any noncompliance findings to the Administrator and during QAPI to ensure ongoing compliance. The Building Services Director is responsible for ensuring sustained compliance. ELEMENT IV: The facility will be in compliance by 1.27.25	1/27/2025

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K0753 SS= F	Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure combustible decorations were prohibited except as permitted by the requirements of 19.7.5.6. This deficient practice could affect all occupants in the event of a emergency. Findings Include: 1. On 12/18/2024 at approximately 12:15 PM, observation revealed wrapping paper on several doors including staff and guest restrooms, and dining room doors decorated in Christmas wrapping paper. 2. On 12/18/2024 at approximately 12:54 PM, observation revealed a decorative mural on cross corridor door near room 604 covering the whole door. This disguising of a door creates confusion during an emergency of where an emergency exit is located.	K0753	K753 ELEMENT I: The facility failed to ensure combustible decorations were prohibited except as permitted by the requirements of 19.7.5.6. This deficient practice could affect all occupants in the event of a emergency. Decorations were removed. ELEMENT II: The Building Services Director or designee will monitor to ensure combustible decorations are not used. Findings will be placed on a log. All staff will be educated regarding combustible decorations. ELEMENT III: The Building Services Director or designee will complete an audit of the monthly compliance logs and report any noncompliance findings to the Administrator and during QAPI to ensure ongoing compliance. The Building Services Director is responsible for ensuring sustained compliance ELEMENT IV: The facility will be in compliance by 1.27.25	1/27/2025

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	3. On 12/18/2024 at approximately 12:54 PM, observation revealed a decorative mural covering both cross corridor doors between the nursing station and office #8 located in 600 Hall. This decorative mural is disguising the cross corridor doors creating confusion during an emergency of where the emergency exit is located. These findings were confirmed by interview with Facility Maintenance at the time of the observations.			
K0754 SS= F	Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that soiled linen or trash containers did not exceed 32 gallons in capacity or an average density of .5 gal/sq. ft. as required by 19.7.5.7. This deficient practice could affect all occupants in the event of a fire emergency.	K0754	K754 ELEMENT I: The facility failed to ensure that soiled linen or trash containers did not exceed 32 gallons in capacity or an average density of .5 gal/sq. ft. as required by 19.7.5.7. This deficient practice could affect all occupants in the event of a fire emergency. The facility will remove all non-wheeled Trash containers from halls/corridors. ELEMENT II The Building Services Director or designee will monitor the halls on a monthly basis to ensure compliance. Findings will be placed on a log. Staff will be educated regarding the use of trash containers, including size and square feet. ELEMENT III: The Building Services Director or designee will complete an audit of the monthly compliance logs and report any noncompliance findings to the Administrator and during QAPI to ensure ongoing compliance.	1/27/2025

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	Findings Include: On 12/18/2024 between the hours of 11:35 AM to 4:05 PM, observation revealed several trash receptacles with an accumulation of trash throughout the facility in resident corridors 100 through 600. Trash receptacles and refuse must be stored in a rated hazard room. These findings were confirmed by interview with Facility Maintenance at the time of the observations.		The Building Services Director is responsible for ensuring sustained compliance. ELEMENT IV: The facility will be in compliance by 1.27.25	
K0920 SS= E	Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by:	K0920	K920 ELEMENT I: The facility failed to ensure power strips are in compliance with NFPA 99, and NFPA 70. This deficient practice could affect 47 occupants in the event of a fire emergency. The facility removed the unapproved power strips from the Therapy gym and will audit to ensure that only approved power strips are in use. ELEMENT II: The Building Services Director or designee will monitor on a monthly basis to ensure compliance. Findings will be placed on a log. All staff will be educated regarding the use of power strips. ELEMENT III: The Building Services Director or designee will complete an audit the monthly compliance logs and report any noncompliance findings to the Administrator and during QAPI to ensure ongoing compliance.	1/27/2025

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EATON COUNTY MEDICAL CARE FACI	530 W BEECH ST CHARLOTTE, MI 48813

(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
	Based on observation and interview, the facility failed to ensure power strips are in compliance with NFPA 99, and NFPA 70. This deficient practice could affect 47 occupants in the event of a fire emergency. Findings Include: On 12/18/2024 at approximately 12:50 PM, observation revealed 6 multi-plug power strip cords located in the therapy gym that service patient care did not meet the UL 1362A or UL 60601-1 rating. These findings were confirmed by interview with Facility Maintenance at the time of the observations.		The Building Services Director is responsible for ensuring sustained compliance ELEMENT IV: The facility will be in compliance by 1.27.25	
K0923 SS= F	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	K0923	K923 ELEMENT I: The facility failed to ensure storage of nonflammable gasses meet all requirements of NFPA 99. This deficient practice could affect all occupants in the event of the emergent need of oxygen. The facility will post laminated signage on doors that reads "CAUTION: OXIDIZING GAS (ES) STORED WITHIN NO SMOKING" as required. The facility will ensure no combustibles are stored within 5 ft. of oxygen storage located in the oxygen storage room between 100 and 200 Hall. ELEMENT II: The Building Services Director or designee will monitor on a monthly basis to ensure compliance. Findings will be placed on a log.	1/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	238510	A. BUILDING _____ B. WING _____	12/18/2024

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	be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure storage of nonflammable gasses meet all requirements of NFPA 99. This deficient practice could affect all occupants in the event of the emergent need of oxygen. Findings Include: 1. On 12/18/2024 at approximately 12:12 PM, observation revealed the oxygen storage room between 100 and 200 Hall did not have signage on the door that reads "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING" as required. 2. On 12/18/2024 at approximately 12:13 PM, observation revealed combustibles are stored within 5 ft. of oxygen storage located in the oxygen storage room between 100 and 200 Hall.		All staff will be educated regarding the storage of oxygen. ELEMENT III: The Building Services Director or designee will complete an audit the monthly compliance logs and report any noncompliance findings to the Administrator and during QAPI to ensure ongoing compliance. The Building Services Director is responsible for ensuring sustained compliance ELEMENT IV: The facility will be in compliance by 1.27.25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	238510	A. BUILDING _____ B. WING _____	**12/18/2024**

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	These findings were confirmed by interview with Facility Maintenance at the time of the observations.			