STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265813	A. BUILDING 01, 02 B. WING _____	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE CENTER	1700 MORNINGSIDE DRIVE CHILLICOTHE, MO 64601

(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
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (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 all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [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.	E 004		

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

Administrator 3-18-25

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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E 004	Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility staff failed to ensure they updated their emergency plan (EP), signed off on it annually, and had all current components in all their EP binders. This had the capacity to affect all residents. The facility had a census of 53 residents. 1. Review of the EP plan showed it did not have a date when it was last reviewed. During an interview on 1/23/25 at 4:28 P.M., the Assistant Administrator (AA) said they were in the EP often and do revisions on a regular basis, but they did not have a specific sheet to show when it was last updated/reviewed. 2. Review of the Succession of Command page last updated 11/2021 showed the only people listed were the Administrator, the AA, and the Director of Nursing (DON). During an interview on 1/23/25 at 4:28 P.M., the AA said she did not realize the order of succession did not include a position that would always be in the building (such as a charge nurse). 3. Review of the undated Shelter in Place Policy and HVAC Outage policy dated 11/2021 showed:	E 004		

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E 004	Continued From page 2 - "Residents will remain in the facility unless the outside temperature drops below 20 degrees Fahrenheit, and the subsequent ambient interior air temperature conditions drop below 68 degrees Fahrenheit in the winter months." and "In the event the facility is unable to provide heat or air condition to keep areas cooled/heated to regulatory requirements. Outside temperatures below 20° and inside temperatures below 68° in the winter months.", respectively. During an interview on 1/23/25 at 4:28 P.M., the AA said the plan needed to reflect that the facility would evacuate if they could not maintain the resident use areas during a loss of heat to 68 degrees or above regardless of the outside/ambient temperature(s). 4. Review of the Evacuation Plan showed the location of evacuation was two churches. During an interview on 1/23/25 at 4:28 P.M., the AA said they had other facilities they would evacuate to and had agreements with them, but they did not make it into all the EP binders. 5. Review of the Water Shut Off Procedure dated 11/2021 showed the plan did not include the staff would start a fire watch (for the sprinkler system being down). During an interview on 1/23/25 at 4:28 P.M., the AA said staff knew to start the fire watch, but that is not reflected in their water shut off procedures. 6. Review of the Computer Failure/Telecommunication Failure/Cyber Attack policy showed the cyber attack section listed good practices to browse the Internet/suspicious	E 004		

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E 004	Continued From page 3 e-mails/keeping antivirus up-to-date... but did not actually show what the facility would do during a cyber attack. During an interview on 1/23/25 at 4:28 P.M., the AA said they had thought about this recently with everything that is happening, including one recent incident that a popular antivirus (CrowdStrike) program on 7/19/24 caused "the blue screen of death" on many computers worldwide. They had started developing policies and procedures on what to do and have implemented some elements of what would mitigate the disaster but did not have them formally in a policy. 7. Review of the COVID-19 Policy written on 4/15/20 and last updated on 3/21/22 was not up-to-date with the procedures and listed the former administrator. During an interview on 1/23/25 at 4:28 P.M., the AA said the former administrator had not worked in the facility for about four years. She realized the COVID-19 policy was not up-to-date when they had their survey the week prior and had not got the updated COVID-19 policy in their EP book(s). 8. Review of the Missing Resident policy did not show that the facility would or when they would call the Department of Health and Senior Services (DHSS) if they had a missing resident. During an interview on 1/23/25 at 4:28 P.M., the AA said DHSS would be notified of a missing resident, but she would need to update the policy to reflect that.	E 004		
K 000	INITIAL COMMENTS	K 000		

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K 000	Continued From page 4 42 CFR 483.90 (a) The facility does not meet the applicable provisions of the 2012 edition of the Life Safety Code of the National Fire Protection Association and related reference documents.	K 000		
K 311 SS=E	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure it did not have penetration from the main floor to the attic space above (this could allow smoke and fire to spread during a fire). The facility had a capacity of 60 and a census of 53 at the time of the survey. 1. Observation on 1/23/25 starting at 11:30 A.M., showed: - A two foot by quarter inch crack in the ceiling in the south hall medication room; - A one inch penetration in the ceiling tiles, a two inch by quarter inch gap around a ceiling tile, and multiple ceiling tiles not secured with minor gaps in the mechanical room closest to the south hall medication room. The ceiling above was plywood	K 311		

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K 311	Continued From page 5 (a combustible material) and the plywood had multiple penetrations that lead to the attic space above. During an interview on 1/23/25 at 4:08 P.M., the Maintenance Supervisor said they should not have any penetrations through the ceiling. He checked for penetrations in the ceiling and filled them when he found them. Record review of the National Fire Protection Association (NFPA) 101, 2012 edition showed: - 8.6 Vertical Openings. - 8.6.2 Continuity. Openings through floors shall be enclosed with fire barrier walls, shall be continuous from floor to floor, or floor to roof, and shall be protected as appropriate for the fire resistance rating of the barrier. - 8.6.3 Continuity Exemptions. The requirements of 8.6.2 shall not apply where otherwise permitted by any of the following: (1) Where penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, pneumatic tube conveyors, and similar items to accommodate electrical, mechanical, plumbing, and communications systems are protected in accordance with 8.3.5.1 and 8.5.6.	K 311		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 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	K 345		

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K 345	Continued From page 6 available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility staff failed to ensure they had a qualified person test, inspect, and maintain the fire alarm system when they allowed a National Institute for Certification in Engineering Technologies (NICET) Level I inspector (apprentice level) to sign off on the annual and semi-annual fire alarm inspections. This had the potential to affect all residents. The facility had a capacity of 60 and a census of 53 residents at the time of the survey. 1. Review of the fire alarm inspection for the last year showed: - An annual fire alarm inspection completed on 7/23/24 by a NICET Level I Fire Alarm System inspector; - A semi-annual fire alarm inspection completed on 1/13/25 by a NICET Level I Fire Alarm System inspector. During an interview on 1/23/25 at 4:08 P.M., the Maintenance Supervisor said he did not realize that a NICET Level I had signed off on both the annual and semi-annual fire alarm inspections. They sent two people out to do them, so he was not sure why the Level I signed off on the inspections. Review of the National Fire Protection Association (NFPA) 72, 2010 edition showed: 10.4.3 Inspection, Testing, and Maintenance Personnel. (SIGTMS) 10.4.3.1 Service personnel shall be qualified and experienced in the inspection, testing, and	K 345		

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K 345	Continued From page 7 maintenance of systems addressed within the scope of this Code. Qualified personnel shall include, but not be limited to, one or more of the following: (1) Personnel who are factory trained and certified for the specific type and brand of system being serviced (2) Personnel who are certified by a nationally recognized certification organization acceptable to the authority having jurisdiction (3) Personnel who are registered, licensed, or certified by a state or local authority to perform service on systems addressed within the scope of this Code (4) Personnel who are employed and qualified by an organization listed by a nationally recognized testing laboratory for the servicing of systems within the scope of this Code	K 345		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 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	K 353		

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K 353	Continued From page 8 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility staff failed to ensure sprinkler heads were not obstructed, all areas that required sprinkler coverage had sprinkler heads, and failed to ensure they did not have ordinary-response (OR) and quick-response (QR) sprinkler heads in the same area. This affected three of eight smoke compartments (partitions in the building designed to prevent the spread of smoke and fire during a fire). The facility had a capacity of 60 and a census of 53 residents at the time of the survey. 1. Observation on 1/23/25 at 12:30 P.M., showed a new wing of the building connected to the therapy room in an older part of the building. The room was not separated by doors/walls. The therapy room had OR sprinkler heads and the new corridor had QR sprinkler heads. 2. Observation on 1/23/25 at 12:40 P.M., showed the elevator control room/pit did not have sprinkler coverage. 3. Observation on 1/23/25 at 1:00 P.M., showed the two sprinkler heads in the dock area were obstructed by the dock door when opened. The room had no other sprinkler coverage. 4. Observation on 1/23/25 at 12:39 P.M. and at 2:00 P.M., showed: - Boxes within six inches of the sprinkler head in the walk-in freezer in the kitchen; - The vending machine within six inches of the sprinkler head in the main corridor near the front	K 353		

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K 353	Continued From page 9 of the building. During an interview on 1/23/25 at 4:08 P.M., the Maintenance Supervisor said: - He did not realize they had a mix of OR and QR sprinkler heads in the same area; - He did not know why the elevator control room would not have sprinkler coverage; - He did not realize when the dock door was open it obstructed the only sprinkler heads in the room; - Items were not supposed to be stored within 18 inches of a sprinkler head and the vending machine had been there for years. Review of the NFPA 25, 2011 edition; 5.2.1.2: The minimum clearance required by the installation standard shall be maintained below all sprinkler deflectors. [Table E-1] Review of NFPA 13, 2010 edition showed: - 8.1 Basic Requirements. - 8.1.1 The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers shall be installed throughout the premises. - 8.3.3.2 Where quick-response sprinklers are installed, all sprinklers within a compartment shall be quick-response unless otherwise permitted in 8.3.3.3. - 8.3.3.3 Where there are no listed quick-response sprinklers in the temperature range required, standard-response sprinklers shall be permitted to be used.	K 353		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills	K 712		

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K 712	Continued From page 10 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 staff failed to ensure they ran drills at varied times and conditions when they ran the night drills at the same time and did not run any drills on the weekends. This had the potential to affect all residents. The facility had a capacity of 60 and a census of 53 at the time of the survey. 1. Review of the fire drills for the past year showed: - A drill on 6/19/24 at 12:00 A.M.; - A drill on 12/27/24 at 12:00 A.M.; - A drill on 3/415/24 at 6:00 A.M.; - A drill on 9/27/24 at 6:00 A.M. During an interview on 1/23/25 at 4:08 P.M., the Maintenance Supervisor said the night shift drills had always been ran at 12:00 A.M. and 6:00 A.M. and he did not know they needed to complete the night shift drills at varied times and conditions, but knew the day and evening shift needed to be. 2. Review of the fire drills for the past year showed: - Two on Monday;. - Two on Tuesday;	K 712		

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K 712	Continued From page 11 - Four on Wednesday; - One on Thursday; - Three on Friday; - Zero on Saturday; - Zero on Sunday. During an interview on 1/23/25 at 4:08 P.M., the Maintenance Supervisor said he did not consider a weekend being varied conditions, but acknowledged that administrative personnel did not usually work the weekend shifts. Review of the National Fire Protection Association (NFPA) 101, 2012 editions, 19.7.1.6 showed: Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.	K 712		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and 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	K 363		

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K 363	Continued From page 12 door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility staff failed to ensure all corridor doors were positive latching and they did not use roller latches. This had the potential to affect one of eight smoke sections (partitions in the building designed to prevent the spread of smoke and fire during a fire). The facility had a capacity of 60 and a census of 53 residents at the time of the survey. 1. Observation on 1/23/25 at 12:25 P.M., showed the two rooms with double doors (activity and HVAC room) on the corridor of the new wing. The double doors utilized a positive latch to connect the two doors together but used roller latches to connect the doors/leaves into their frames. These doors did not have automatic flush bolts to secure the doors within the frames. During an interview on 1/23/25 at the same time, the Maintenance Supervisor said the doors were installed on the new hallway that was built in 2019. He assumed the construction company put in the correct doors/latches to meet the Life Safety Code requirements. Review of the National Fire Protection Association (NFPA) 101, 2012 edition showed: - 18.3.6.3 Corridor Doors. - 18.3.6.3.5 Doors shall be self-latching and	K 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265813	A. BUILDING **01, 02** B. WING _____	**01/23/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE CENTER	**1700 MORNINGSIDE DRIVE** **CHILLICOTHE, MO 64601**

(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
K 363	Continued From page 13 provided with positive latching hardware. - 18.3.6.3.8 Corridor doors utilizing an inactive leaf shall have automatic flush bolts on the inactive leaf to provide positive latching. - 18.3.6.3.9 Roller Latches. - 18.3.6.3.9.1 Roller latches shall be prohibited, except as permitted by 18.3.6.3.9.2. 18.3.6.3.9.2 Roller latches shall be permitted for acute psychiatric settings where patient special clinical needs require specialized protective measures for their safety, provided that the roller latches are capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door.	K 363		

PLAN OF CORRECTION

Provider/Supplier Name:	Morningside Center 265813
Street Address, City, Zip:	1700 Morningside Drive Chillicothe, MO 64601
Date of Survey:	01/13 - 01/16/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		
ID PREFIX TAG	**PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)**	**COMPLETION DATE**
E 004 483.73 a	The emergency preparedness manual will be reviewed and updated annually and as needed by the maintenance coordinator and assistant administrator. A cover sheet has been added to the master Disaster Preparedness Manual with signature and date of review. The maintenance coordinator and assistant administrator will notify the Administrator when review has been completed. Policies indicated in the Statement of Deficiencies will be updated by March 1, 2025 . The EP manual will be reviewed by the QAPI committee on an annual basis and as needed.	03/04/2025
	The succession of command policy has been updated to reflect a staff person who is always in the building at all times, the charge nurse. The nurse will be in charge until the Administrator, Assistant Administrator or Director of Nursing can resume command	
	Shelter in place and HVAC policy has been updated to reflect that evacuation would occur if the residents use areas that could not maintain proper temperature of 68* in winter months and below 81* in summer months.	
	The evacuation plan has residents being evacuated to two local churches, and mutual aid agreements with nursing homes and hospitals if needed. This wording has been added to the evacuation procedure to show where residents would be transported to, from the church after they have been assessed, and staff and supplies were gathered to go with them.	

	The utility outage policy/procedure has been updated with the addition of start fire watch if water is off for more than four hours.	
	Cyber attack policy has been updated to reflect what procedure to follow in the case of a cyber attack. Computer affected would be disconnected from the network. Call Administrator, call Greenhills communications (IT), the contact information has been added to the call list. Demographic and contact information are kept in a Evacuation manual, located in the CMS report room, physician orders are kept in paper form in the business office area, an offline report can be accessed without internet through the CMS report room computer.	
	The director of nursing had updated the COVID-19 policy but the policy had not been added to the EP manual. The updated policy has been added to the EP manual. The updated policy has been added to the EP manual by the assistant administrator on 2.14.2025.	
	The Missing resident policy updated on 2.13.2025 by the assistant administrator to show that the Administrator or designee would notify DHSS region 4 of a missing resident within two hours of notification. DHSS number has been included in the policy.	
	This deficiency has the potential to affect all residents. Facility census was 53.	

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Provider/Supplier Name:	Morningside Center 265813
Street Address, City, Zip:	1700 Morningside Drive Chillicothe, MO 64601
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K311	K 311 Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least	03/04/2025
	On 1/28/25 To maintain and ensure Morningside Center meets 2012 edition of the NFPA Life Safety Codes, Morningside Center's Maintenance Coordinator caulked and sealed the two-foot by quarter inch crack in the south medication room, and the one-inch penetration and the two inch by quarter inch gap in the ceiling tile in the mechanical room closest to the south hall. **The Maintenance Coordinator has developed a quarterly schedule to check ceilings for penetrations to prevent exposure to the attic. The Maintenance Coordinator will document his/her findings and submit those findings at the February 2025 QA meeting. The maintenance Coordinator will continue to report his findings and repairs, if any, quarterly through 1/2026.** **QA members will be assigned by the Administrator and/or Assistant Administrator on a quarterly basis though 1/26 to review specific areas of the facility for holes or penetrations in the ceilings which open into the attic space. Each assigned QA member will document their findings. Any exposed areas will be reported immediately to the Maintenance Coordinator for immediate repair. QA members will submit their documented findings to the maintenance coordinator**	

	who will review with the administrator. The maintenance coordinator will submit his/her report at each quarterly QA meeting to assure compliance.	
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K345	K 345 Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 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.	03/04/2025
	Fire Alarm System Testing and Maintenance. On 2/10/2025 the maintenance coordinator contacted the facilities Fire Safety Company regarding the deficiencies cited from the recent survey conducted by DHSS region 4 and explained the inspections had not been completed by a Level two or higher Technician as required by NFPA 72. The facilities maintenance coordinator requested that the fire protection company complete the inspections again by a qualified technician. **2/13/25 The facilities maintenance coordinator emailed the fire protection company and requested that the annual fire alarm inspection be completed by a level two NICET or higher and the inspection as be to completed as soon as possible but no later than 3/4/25. The fire protection company shall provide technician credentials to the maintenance coordinator before the inspection can take place to maintain compliance with NFPA 70, 72.** **At the February 2025 QA meeting the Maintenance Coordinator will provide the QA committee with an update as to when the Fire Safety Company is**	

	scheduled to complete the inspection by a qualified technician. **When the Fire Safety Company completes the required inspections, their paperwork will be reviewed by the Maintenance Coordinator and/or Administrator and/or Asst. Administrator prior to the technician leaving the facility , to insure all required testing has been completed, and the form is dated and signed by the inspector and his/her license number is on the form or any other credentials to indicate he/she is a qualified individual.**	
	The Assistant Administrator will coordinate with the maintenance coordinator regarding when inspections and testing are to be completed and verify, they are being completed by a qualified individual. Inspection must be signed only by maintenance coordinator, administrator, or the assistant administrator to maintain compliance, no other staff may sign the report. The maintenance coordinator will keep written documentation that inspections and testing have been completed by a qualified individual. The Assistant Administrator will notify the Maintenance Coordinator immediately of an inspection completed by a non-qualified technician. Maintenance coordinator will provide written findings to the QA committee quarterly until 1/2026.	
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K353	**Sprinkler System and Maintenance. On 2/10/2025 the Maintenance Coordinator contacted the facilities Fire Safety Company regarding the cited deficiencies and explained the necessity of these repairs to meet NFPA 25 requirements. Also discussed was a schedule for required repairs. The fire protection company will be on site on 2/13/25 to review the deficiencies cited and prepare a plan to correct them in a timely manner. On 2/13/25 the fire safety company was at the facility to measure and determine what sprinkler heads need to be obtained and to ensure compliance and how much installation time will be required to install sprinkler heads in the therapy room to match the quick response heads on the new wing. The fire safety company also measured the addition of sprinkler heads in the elevator control room/pit. The fire safety company determined that the sprinkler head in the dock area must be relocated to ensure proper sprinkler coverage. Maintenance coordinator will coordinate with snack and beverage company to have vending machines moved by 3/4/25 to ensure fire safety compliance. On 2/10/25 the maintenance coordinator notified the dietary manager of 18 inch's clearance around all sprinkler heads including those in the walk freezer must be maintained. On 2/10/25 the items were removed, and the maintenance coordinator installed signage indicating appropriate clearance level. The Dietary manager will also train staff on this requirement.**	03/04/2025

	K353 continued **The facilities Maintenance Coordinator has developed a check list to monitor all areas of the building for compliance with NFPA sprinkler regulations. The maintenance coordinator will document his/her findings and submit them to the Administrator and Assinstant Administrator to review monthly. Findings will also be presented to the QA members for review in the February 2025 QA meeting.** **QA members will be assigned by the Administrator to review specific locations to verify that all sprinkler heads have a minimum of 18 inches of clearance and are not obstructed in any way. Each QA member will document their findings, and any problem sprinkler heads will be reported to the Maintenance Coordinator for immediate repair. QA members will submit their findings at the February 2025 QA meeting. The QA committee will determine if further monitoring is needed. The maintenance Coordinator will continue to report his findings and repairs, if any, quarterly through 1/2026** **This deficiency has the potential to affect all residents. Facility census was 53.**	

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K363	**K363 Corridor Doors- 2/10/25 Maintenance coordinator contacted the fire door repair contractor and notified them of the stated deficiencies with the doors stated in the report, the maintenance coordinator also expressed that these repairs need to be completed by 3/4/25 to maintain fire safety. The maintenance coordinator will notify the Administrator an Assistant Administrator when the doors are scheduled for repair by the contractor.** **2/13/25 Maintenance coordinator contacted the fire door contractor and DHSS about the doors cited and after conversation with DHSS it was determined the door of the HVAC does meet the NFPA 101 requirements evidenced by, automatic or manual flush bolt can be used on the inactive leaf as long as it automatically creates the smoke-proof seal when self-closed. The HVAC Door has top and bottom flush bolts on the inactive leaf which make the HVAC Complaint with NFPA 101. The Second door cited that opens to the activity storage closet, it is not complaint evidenced by not having the floor bolt socket installed in the floor. Maintenance coordinator will install floor socket on 2/14/25 to gain compliance With NFPA 101.** **QA members will be assigned by the Administrator to review all the fire doors to verify proper operation of doors. Each QA member will document their findings of the doors, and any noncompliance will be reported to the Maintenance Coordinator for immediate repair. QA members will submit their findings at the quarterly February 2025 QA meeting. The facility will also**	03/04/2025

	continue to have a Fire Safety Compliance contractor inspecting the doors annually and any deficiencies will K363 continued **be noted in report submitted to maintenance coordinator and Administrator for repair.** **The Maintenance Coordinator has developed a Monthly schedule to check the corridor doors for proper operation and correct hardware. The Maintenance Coordinator will document his/her findings and submit those findings at the February 2025 QA meeting. The QA committee will determine if further monitoring is needed. The maintenance Coordinator will continue to report his findings and repairs, if any, quarterly through 1/2026.** **This deficiency has the potential to affect all residents. Facility census was 53.**	

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K712	**K712 Fire Drills – 2/10/25 The Maintenance Coordinator Has Developed a new fire drill schedule that has a varied conditions including two weekend drills, varying times on all shifts including day, evening, and night shift, also varying days though out the week.** **The maintenance coordinator will submit the fire drill schedule to the Assistant Administrator to verify the drills are held at expected and unexpected times under varying conditions including two weekend drills, at least one quarterly on each shift. The Fire Drill Reports will be submitted to the Assistant Administrator to Maintain Compliance with the set schedule of the drills. If a drill is missed or not completed at the correct time an additional drill will take place to maintain compliance with varying times and conditions. The Assistant administrator will monitor drills and schedule to maintain compliance with NFPA 101.** **Maintenance coordinator will maintain written records of fire drills to maintain compliance with NFPA 101.Maintenance Coordinator and Assistant Administrator will document that the drills are being done at the assigned times monthly and will report at quarterly QA meetings until 1/2025.** **This deficiency has the potential to affect all residents. Facility census was 53.**	03/04/2025

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