STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155813	A. BUILDING -- B. WING	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VILLAGES AT HISTORIC SILVERCREST THE	1 SILVERCREST DRIVE NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/06/2024 Facility Number: 012619 Provider Number: 155813 AIM Number: 201238590 At this Emergency Preparedness survey, The Villages at Historic Silvercrest was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 56 certified beds, with a current census of 46. Quality Review completed on 08/08/24	E 0000	This plan of correction is to serve as The Historic Villages of Silvercrest Health Campus credible allegation of compliance. Submission of this plan of correction does not constitute an admission by The Historic Villages of Silvercrest Health Campus or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility, nor does this submission constitute an agreement or admission of the survey allegations. Attached you will find the plan of correction for The Historic Villages of Silvercrest Health Campus Life Safety Survey that was completed on 8/6/2024. The plan of correction and specific correction actions are prepared and/or executed in compliance with State and Federal Laws. The campus' date of alleged compliance is: 8/16/2024. We initiated immediate interventions when concerns were identified during the survey. If you need any information or paperwork, please contact me at 1(502)-693-1143. Sincerely, Tori Harper, Executive Director	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Victoria Roby Harper	Executive Director	08/21/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/06/2024 Facility Number: 012619 Provider Number: 155813 AIM Number: 201238590 At this Life Safety Code Survey, The Villages at Historic Silvercrest was found in substantial compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This five story facility with a basement was determined to be of Type II (222) construction and was fully sprinkled. The entire facility was surveyed with the exception of the Assisted Living on the fourth and fifth floors. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 56 and had a census of 46 at the time of this survey. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 08/08/24	K 0000	This plan of correction is to serve as The Historic Villages of Silvercrest Health Campus credible allegation of compliance. Submission of this plan of correction does not constitute an admission by The Historic Villages of Silvercrest Health Campus or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility, nor does this submission constitute an agreement or admission of the survey allegations. Attached you will find the plan of correction for The Historic Villages of Silvercrest Health Campus Life Safety Survey that was completed on 8/6/2024. The plan of correction and specific correction actions are prepared and/or executed in compliance with State and Federal Laws. The campus' date of alleged compliance is: 8/16/2024. We initiated immediate interventions when concerns were identified during the survey. If you need any information or paperwork, please contact me at 1(502)-693-1143. Sincerely, Tori Harper, Executive Director	

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K 0341 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm annunciator panels near room 305 was protected. NFPA 72, National Fire Alarm and Signaling Code Section 10.10.1 states a means for turning off activated alarm notification appliance(s) shall be permitted only if it complies with 10.10.3 through 10.10.7. Section 10.10.3 states the means shall be key-operated or located within a locked cabinet, or arranged to provide equivalent protection against unauthorized use. This deficient practice could affect all occupants. Findings include: Based on observation on 08/06/2024 between 12:00 PM and 2:25 PM with the Director of Plant Operations and Campus Support, the fire alarm annunciator panel door had a key inserted into the lock. The annunciator panel was located on the wall in the 3rd floor nurses' station near room 305 where staff, residents, and visitors have access.	K 0341	**What Corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice;** Key was removed from the 3rd floor annunciator near room 305 and given to charge nurse for access The DPO and ADPO were provided education by the ED that a key-operated panels key must be arranged to provide protection from unauthorized use. ***How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All Occupants in the building have a potential to be	08/08/2024

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	Based on interview at the time of the observation, Campus Support agreed there was a key in the lock of the annunciator panel and removed the key. This finding was reviewed with the Director of Plant Operations and Campus Support at the exit conference. 3.1-19(b)		affected by this deficient practice. DPO and/or Designee will audit to ensure that keys are not in panels and with charge nurse 1x weekly for 1 month and then 1x monthly for 2 months. ***What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur;** The DPO and ADPO were provided education by the ED that a key-operated panels key must be panels key must be arranged to provide protection from unauthorized use. Audits were put in place to be completed by DPO and/or designee ***How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e…, what quality assurance program will be put into practice?** The DPO will monitor the panels and ensure that the key is not in the panel and with charge nurse. This audit will be completed 1x weekly for 1 month and then 1x monthly for 2 months. by the DPO and/or designee and monitored in QAPI campus meeting in order to determine compliance. Findings s suggestive of 100% compliance may result in cessation of the	

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			monitoring plan.	
K 0351 SS=F Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation, review and interview, the facility failed to ensure the installation of the sprinkler system met the requirements of NFPA 13. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition; Section 6.2.9.6 states one sprinkler wrench as specified by the sprinkler manufacturer shall be provided in the cabinet for each type of sprinkler installed to be used for the removal and installation of sprinklers in the system. Annex A is not a part of the requirements but is included for informational purposes only. A.6.2.9.6 states one sprinkler wrench design can be appropriate for many types of sprinklers and	K 0351	***What Corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice;** The appropriate sprinkler wrench was purchased and delivered to the campus on 8/16/24 DPO and ADPO inserviced regarding sprinkler wrench and what type should be available in the cabinet.	08/16/2024

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	should not require multiple wrenches of the same design. This deficient practice could affect all occupants within the facility. Findings include: Based on observation with the Director of Plant Operations and Campus Support on 08/06/2024 between 12:00 PM and 2:45 PM, the spare sprinkler cabinet was not equipped with a special sprinkler wrench specified by the sprinkler manufacturer. The facility did have an adjustable wrench in the spare sprinkler cabinet, however, this is not the appropriate type of wrench for sprinkler heads. Based on interview at the time of observation, the Director of Plant Operations stated he did not have a special sprinkler wrench in the building. This finding was reviewed with the Director of Plant Operations and Campus Support at the exit conference. 3.1-19(b)		***How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All occupants within the facility could be affected by this deficient practive. The DPO completed an audit to ensure that the correct sprinkler wrench was available. ***What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur;** The correct wrench was ordered and delivered on 8/16/24 and placed in the cabinet. The DPO and/or Designee will audit the cabinet for the correct sprinkler wrench 1x month for 6 months to ensure that the correct wrench is available. ***How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e…, what quality assurance program will be put into practice?** The DPO will ensure that the correct sprinkler wrench is available in the cabinet monthly The audit will be completed by the DPO and/or designee 1X month for 6 months. Findings will be reviewed in QAPI committee meeting.	

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K 0353 SS=F Bldg. 01	NFPA 101 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 1. Based on record review and interview, the facility failed to ensure all private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2011 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Table 7.1.1.2 requires wet and dry barrel hydrants to be inspected annually and after each operation. This deficient practice affects all residents in the facility. Findings include: Based on record review on 08/06/2024 between 9:30 AM and 12:00 PM with the Director of Plant Operations and Campus Support, fire hydrant annual testing documentation indicated the facility's private fire hydrants were last inspected	K 0353	***What Corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice;** Fire hydrants were inspected and up to date on inspection as of 8/8/24 by the contractor. Ceilings and penetrations were fire caulked on 8/13/24. DPO and ADPO were provided education by the ED that wet and dry barrel hydrants must be inspected annually and after each operation, fire pumps must be inspected annually and that ceilings must be free from significant irregularities, lumps and	08/13/2024

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	July 2023. Based on interview at the time of record review, the Director of Plant Operations stated the contractor had been at the facility last week to complete the inspection but had to leave and would return on 08/08/2024. This finding was reviewed with the Director of Plant Operations and Campus Support at the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure the fire pump was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2011 Edition the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems required fire pumps to be inspected annually. This deficient practice could affect all staff, residents, and visitors. Findings include: Based on record review on 08/06/2024 between 9:30 AM and 12:00 PM with the Director of Plant Operations and Campus Support, fire pump annual testing documentation indicated the facility's fire pump was inspected July 2023. Based on interview at the time of record review, the Director of Plant Operations stated the contractor had been at the facility last week to complete the inspection but had to leave and would return on 08/08/2024. This finding was reviewed with the Director of Plant Operations and Campus Support at the exit conference.		indentations. ***How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** This deficient practice could affect all residents, staff and visitors. This requirement was added into our TELS system as an annual audit to ensure ongoing compliance. ***What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur;** DPO and ADPO were provided education by the ED that wet and dry barrel hydrants must be inspected annually and after each operation, fire pumps must be inspected annually and that ceilings must be free from significant irregularities, lumps and indentations. The DPO and/or designee will ensure that this audit is being conducted via the TELS system annually and will do spot checks throughout the building on ceiling spaces to ensure no abnormalities. ***How the corrective action (s)**	

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	3.1-19(b) 3. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 laundry rooms and 1 of 1 ground floor nursing supply rooms. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect at least 4 staff in the kitchen. Findings include: Based on observation with the Director of Plant Operations and Campus Support on 08/06/2024 between 12:00 PM and 2:45 PM, the following was observed: a. a penetration in the ceiling of the laundry room near the AC unit of 6 inches by 2 inches b. a 6 inch by 8 inch penetration in the ceiling tile behind the HVAC system in nursing supply c. a 6.5 inch crack in a ceiling tile in nursing supply near the HVAC system d. a 2 inch penetration around piping in nursing supply near the HVAC system Based on interview at the time of observation, the Director of Plant Operations and Campus Support agreed there were penetrations in the ceiling in the aforementioned locations and provided the measurements. This finding was reviewed with the Director of Plant Operations and Campus Support at the exit conference.		**will be monitored to ensure the deficient practice will not recur, i.e…, what quality assurance program will be put into practice?** The audit has been placed in TELS and is due 11 months from the date of compliance.	

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K 0355 SS=E Bldg. 01	3.1-19(b) NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to inspect 1 of 1 fire extinguishers on the ground floor across from medical records and 1 of 1 laundry room fire extinguishers each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self-expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push-to-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person	K 0355	***What Corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice;** The Fire extinguishers that were found to have not been inspected have now been inspected and have bee added to the inspection log. The DPO/ADPO were in-serviced by the ED about the importance of inspecting all fire extinguishers throughout the building. ***How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** This deficient practice could have impacted 5 employees in the affected area. DPO and/or designee will audit the completed inspection 1x month for 6 months to ensure that the fire extinguishers are being check monthly.	08/07/2024

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	performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect at least 5 staff in these areas. Findings include: Based on observation during a tour of the facility on 08/06/2024 between 12:00 PM and 2:45 PM with the Director of Plant Operations and Campus Support, the fire extinguisher located on the ground floor across from medical records had not been signed off to indicate in was inspected in July 2024 and the fire extinguisher located in the laundry room had not been signed off to indicate it was inspected in June 2024 and July 2024. Based on interview at the time of observation, the Director of Plant Operations agreed the fire extinguishers in the aforementioned locations had not been checked for the previously mentioned months. This finding was reviewed with the Director of Plant Operations and Campus Support at the exit conference. 3.1-19(b)		***What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur;** The DPO and ADPO were provided education about the importance of fire extinguisher checks. Audits were put into place to ensure all fire extinguishers are being checked monthly. ***How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e…, what quality assurance program will be put into practice?** The DPO will monitor the checks to ensure they are happening monthly via the updated log sheet and audit process. The audit will be completed 1x month for 6 months by the DPO/ADPO and monitored in QAPI campus meeting in order to determine compliance.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage			

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VILLAGES AT HISTORIC SILVERCREST THE	1 SILVERCREST DRIVE NEW ALBANY, IN 47150

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	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.			
	Based on observation and interview, the facility failed to ensure 1 of 1 oxygen rooms near room 305, 1 of 1 fire tower doors on the 2nd floor, 1 of 1	K 0363	***What Corrective action (s) will be accomplished for those residents found to have been**	08/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155813	A. BUILDING 01 B. WING	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VILLAGES AT HISTORIC SILVERCREST THE	1 SILVERCREST DRIVE NEW ALBANY, IN 47150

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	storage room doors by therapy, and 1 of 1 dietary delivery doors were able to latch in the frame. This deficient practice could affect staff, visitors and at least 10 residents. Findings include: Based on observation during a tour of the facility on 08/06/2024 between 12:00 PM and 2:45 PM with Campus Support and the Director of Plant Operations, the doors in the following locations were unable to latch into the frame: a. oxygen room near room 305 b. fire tower door on floor 2 c. storage room door by therapy d. dietary delivery door leading to the exterior of the building Based on interview at the time of observation, the Director of Plant Operations and Campus Support agreed the doors in the aforementioned locations did not latch fully into the frame. This finding was reviewed with the Director of Plant Operations and Campus Support at the exit conference. 3.1-19(b)		**affected by the deficient practice;** An initial audit of the 4 doors was completed to ensure that all doors would latch in the frame. The DPO/ADPO were in-serviced the by the ED that all doors protecting corridor openings must latch. ***How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** This deficient practice could affect staff, visitors and at least 10 residents. Doors will be audited to ensure latch ***What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur;** Audit will be conducted by DPO/ADPO daily (M-F) for 2 weeks, 2 times a week for 4 weeks and 1 times week ongoing. ***How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e…, what quality assurance program will be put into practice?** The DPO will monitor the audits and they will monitored in	

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			QAPI campus meeting in order to determine compliance.	
K 0914 SS=E Bldg. 01	NFPA 101 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) Based on record review and interview; the facility failed to ensure complete documentation was available for all nonhospital-grade electrical receptacles in all resident room locations tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered,	K 0914	***What Corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice;** Receptacle testing was completed on 8/13/24 throughout the building The DPO/ADPO were	08/15/2024

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	shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on record review on 08/06/2024 between 9:30 AM and 12:00 PM with the Director of Plant Operations and Campus Support annual receptacle testing for non-hospital-grade receptacles documentation indicated the last receptacle testing had been completed in July 2023. Based on interview at the time of record review, the Director of Plant Operations stated receptacle testing was due to be completed in August 2024 and it must have been completed early in 2023. This finding was reviewed with the Director of Plant Operations at the exit conference. 3.1-19(b)		in-serviced the by the ED regarding receptacle testing and inspection. ***How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** This deficient practice could affect all residents. Receptacle testing was completed. ***What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur;** Annual receptacle testing was added into TELS with an annual check date of August. ***How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e…, what quality assurance program will be put into practice?** The DPO and/or designee will monitor the TELS audit and this will be monitored in QAPI campus meeting in order to determine compliance.	