STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155653	A. BUILDING -- B. WING	08/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARBOR HEALTH & REHAB	5025 MCCOOK AVE EAST CHICAGO, IN 46312

(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: 08/14/2023 Facility Number: 000108 Provider Number: 155653 AIM Number: 100267410 At this Emergency Preparedness survey, Harbor Health & Rehab was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 117 beds which are dually certified for Medicare and Medicaid. At the time of the survey, the census was 67. Quality Review completed on 08/15/23	E 0000		
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rosa McGowen	VP of Operations	08/30/2023

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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	155653	A. BUILDING -- B. WING	08/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARBOR HEALTH & REHAB	5025 MCCOOK AVE EAST CHICAGO, IN 46312

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	systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain			

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	155653	A. BUILDING -- B. WING	08/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013.			

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	(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and VP of Operations on 08/14/23 between 09:15 a.m. to 11:29 a.m., the generator lacked monthly load testing and weekly inspections required by LSC and NFPA 110. Based on interview at the time of record review, the Maintenance Director acknowledged and agreed that the only documentation he had was available in the paperwork provided. The findings were reviewed with the VP of Operations and Maintenance Director at the exit conference.	E 0041	**E 041- Hospital CAH and LTC Emergency Power** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** · The generator monthly load testing and weekly inspection log are current and in compliance. **2) How the facility identified other residents:** · Visitors, staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice.	08/23/2023

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			2) Measures put into place/ System changes: · Maintenance Director will complete weekly inspection and will document on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator /designee by 8/23/23. · The Maintenance Director is responsible for compliance. **4) How the corrective actions will be monitored:** · The Administrator will review the Preventative Maintenance Worksheets monthly. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 8/23/23**	

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	155653	A. BUILDING 01 B. WING	08/14/2023

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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: 08/14/2023 Facility Number: 000108 Provider Number: 155653 AIM Number: 100267410 At this Life Safety Code Survey, Harbor Health & Rehab was found not in 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 two story facility determined to be of Type II (222) construction was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and in areas opened to the corridors. Battery operated smoke detectors are installed in all resident sleeping rooms. The building is partially protected by a diesel powered emergency generator. The facility has 117 beds which are dually certified for Medicare and Medicaid and a census of 67 at the time of this survey All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except two detached storage sheds.	K 0000		

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	Quality Review completed on 08/15/23			
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on records review, observation, and interview, the facility failed to ensure 2 of 2 battery backup lights were tested monthly. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all building occupants when work is needed in the transfer switch room during a power outage. Findings include: Based on an observation during a tour of the facility with the Maintenance Director and VP of Operations on 08/14/23 between 11:56 a.m. and 1:33 p.m., there was a battery powered emergency light in the generator transfer room and another in the fire pump room. Based on records review between 09:15 a.m. and 11:29 a.m., documentation of a monthly 30 second test for the battery powered emergency light was available at the time of survey, but the records were incomplete. There was missing monthly testing for October, November and December of 2022 along with January and February of 2023. Based on an interview at the time of record review and observation, the Maintenance Director agreed there was missing monthly testing and stated he	K 0291	**K291- NFPA 101 Emergency Lighting** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1)**Immediate actions taken for those residents identified:** · Battery powered emergency light inspection records for the generator transfer room and fire pump room are current and in compliance.	08/23/2023

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	could not find any other documentation to confirm if the tests had been done. This finding was reviewed with the VP of Operations and Maintenance Director during the exit conference. 3.1-19(b)		**2) How the facility identified other residents:** · Visitors, staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. **1) Measures put into place/ System changes:** · The Maintenance Director or Designee will inspect battery powered emergency lights monthly and will document on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator /designee by 8/23/23. · The Maintenance Director is responsible for compliance. **4)How the corrective actions will be monitored:** · The Administrator will review the Preventative Maintenance Worksheets monthly. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as	

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			indicated. **5)Date of compliance: 8/23/23**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility	K 0321	**K321 NFPA 101 HAZARDOUS**	08/23/2023

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	failed to ensure the corridor doors to 1 of 1 storage rooms which is a hazardous area containing combustible storage and greater than 50 square feet was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect approximately 20 staff and residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 08/14/23 between 11:56 a.m. and 1:33 p.m., room 122, a hazardous storage room that was greater than 50 square feet, was equipped with self-closing device but did not latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director agreed the room was used as storage, was larger than 50 square feet, and stated the latching hardware of the door and door frame was damaged and would need to be fixed. Findings were discussed with the Maintenance Director and VP of Operations at exit conference. 3.1-19(b)		**AREAS- ENCLOSURE** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1)**Immediate actions taken for those residents identified:** · Room 122 door latching hardware was replaced to ensure proper closure. **2) How the facility identified other residents:** · Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · The Maintenance Director or	

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			Designee will inspect ten (10) doors weekly for one month and monthly thereafter to ensure compliance. The Maintenance Director will document on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator /designee by 8/23/23. · The Maintenance Director is responsible for compliance. **4)How the corrective actions will be monitored:** · The Administrator will review the Preventative Maintenance Worksheets monthly. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)Date of compliance: 8/23/23**	
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program			

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	complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice affects all occupants in the facility. Findings include: During records review with the Maintenance Director and VP of Operations on 08/14/23 between 09:15 a.m. and 11:29 a.m., no documentation was provided regarding a visual inspection of the fire alarm system six months prior to the annual fire alarm inspection conducted on 07/25/23. Based on interview at the time of records review, the Maintenance Director stated no documentation could be found about a visual fire alarm inspection and was unaware if the inspection was conducted.	K 0345	**K345 NFPA 101 Fire Alarm System- Testing and Maintenance** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified:** · Fire Alarm System visual inspection completed. **2) How the facility identified other residents:** · Staff, and residents that reside at the facility have the	08/23/2023

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	This finding was reviewed with the VP of Operations and Maintenance Director at the exit conference. 3.1-19(b)		potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · The Maintenance Director or Designee will complete visual inspection by-annually of Fire Alarm System and will document on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator /designee by 8/23/23. · · The Maintenance Director is responsible for compliance. **4)How the corrective actions will be monitored:** · The Administrator will review the Preventative Maintenance Worksheets monthly. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)Date of compliance: 8/23/23**	

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HARBOR HEALTH & REHAB	5025 MCCOOK AVE EAST CHICAGO, IN 46312

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K 0351 SS=E 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 and interview, the facility failed to maintain the ceiling construction in 1 of 4 smoke compartments in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect approximately 5 staff and an unknown number of residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director 08/14/23 between	K 0351	**K351 NFPA 101 Sprinkler System- Installation** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of*	08/23/2023

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	155653	A. BUILDING 01 B. WING	08/14/2023

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	11:56 a.m. and 1:33 p.m., in the back closet of the Medical Records Office, the sprinkler head had a missing escutcheon plate that did not completely cover the hole around the sprinkler which left an approximately half-inch hole between the ceiling and the sprinkler head. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned area was missing an escutcheon and stated the sprinkler company is supposed to be in the facility soon and wiould have them replace the missing escutcheon. Findings were discussed with the Maintenance Director and VP of Operations 3.1-19(b)		*deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified:** · Sprinkler head escutcheon was installed. **2) How the facility identified other residents:** · Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · The Maintenance Director or Designee will complete monthly visual inspection of Sprinkler Heads and will document it on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator /designee by 8/23/23. · The Maintenance Director is responsible for compliance. **4)How the corrective actions will be monitored:**	

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			· The Administrator will review the Preventative Maintenance Worksheets monthly. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)Date of compliance: 8/23/23**	
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 provide written documentation or other evidence the sprinkler system components	K 0353	**K353 NFPA 101 Sprinkler System- Maintenance and Testing**	08/23/2023

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	had been inspected and tested for 3 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review with the VP of Operations and Maintenance Director on 08/14/23 between 09:15 a.m. and 11:29 a.m., the only sprinkler quarterly inspection provided was from 08/05/22. No other sprinkler inspections within the past 12 months could be provided. Based on interview at the time of record review, the Maintenance Director stated that the facility was in the process of switching providers and the sprinkler company has been out within the last 12 months, however no inspection paperwork could be provided. Later		**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified:** · Sprinkler Quarterly inspections is current and in compliance. · Sprinkler heads in breakroom, laundry room and second floor dining room were cleaned. **2) How the facility identified other residents:** · Staff, Visitors, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. **3) Measures put into place/**	

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	during record review, the VP of Operations was able to get ahold of the sprinkler inspection company and requested documentation, but the company could not provide documentation by the end of the survey. Findings were discussed with the Maintenance Director and VP of Operations at exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and VP of Operations on 08/14/23 between 09:15 a.m. and 11:29 a.m., there was no monthly inspection of the wet pipe sprinkler system's gauges and valves for the months prior to March of 2023. During an interview at the time of record review, the Maintenance Director stated that the only documentation he has was the forms		**System changes:** · The Maintenance Director or Designee will complete monthly visual inspection of Sprinkler Heads and monthly inspection of the wet pipe system to include gauges and valves. Inspections will document it on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator /designee by 8/23/23. · The Maintenance Director is responsible for compliance. **4)How the corrective actions will be monitored:** · The Administrator will review the Preventative Maintenance Worksheets monthly. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)Date of compliance: 8/23/23**	

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	that he had started when hired and that other inspections could not be located. Findings were discussed with the Maintenance Director and VP of Operations at exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 2 of 4 sprinkler heads in the breakroom and 2 of 6 sprinkler heads in laundry were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect approximately 20 residents and staff in one smoke compartment. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 08/14/23 between 11:56 a.m. and 1:33 p.m. two sprinkler heads in the second floor dining lounge were loaded with dirt and lint could barely see the color of the bulb. Based on interview at the time of observation, the Maintenance Director confirmed the aforementioned sprinkler heads showed dirt accumulation and loading. Findings were discussed with the Maintenance			

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	Director and VP of Operations at exit conference 3.1-19(b)			
K 0355 SS=E Bldg. 01	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 ensure 1 of 1 portable fire extinguishers in the maintenance shop were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice was not in a resident care area but could affect staff and residents near the second floor nurses station. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 08/14/23 between 11:56 a.m. and 1:33 p.m., an ABC portable fire extinguisher behind the nurses desk was sitting on the floor unsecured. Based on interview at the time of observation, the Maintenance Director agreed the extinguisher was sitting on the floor and stated it is left over from when the wing of the building had some work done and was left there by accident.	K 0355	**K355 NFPA 101 Portable Fire Extinguisher** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified:** · Portable fire extinguishers removed.	08/23/2023

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	Findings were discussed with the Maintenance Director and VP of Operations at exit conference. 3.1-19(b)		**2) How the facility identified other residents:** · Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · The Maintenance Director or Designee will complete monthly visual inspection of Portable fire extinguishers to ensure proper installation and will document it on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator /designee by 8/23/23. · The Maintenance Director is responsible for compliance. **4)How the corrective actions will be monitored:** · The Administrator will review the Preventative Maintenance Worksheets monthly. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to	

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			revise the plan of correction as indicated. **5)Date of compliance: 8/23/23**	
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 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			

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	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. 1. Based on observation and interview, the facility failed to ensure 3 of 57 resident room corridor doors on the southwest wing were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect approximately 6 residents. Findings include: Based on observation with the Maintenance Director on 08/14/23 between 11:56 a.m. and 1:33 p.m., the corridor doors to resident rooms 116, 120, and 212 did not latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director agreed that the aforementioned doors did not latch into the frame and would need adjusting. The finding was reviewed with the VP of Operations and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 door to the corridor would completely resist the passage of smoke. This deficient practice could affect approximately 20 residents, as well as staff and visitors. Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K 0363	**K363 NFPA 101 Corridor- Doors** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified:** · The corridor doors to resident's rooms 116, 120, and 212 were adjusted to ensure proper closure. · Janitor closet door handle near room 212 replaced.	08/23/2023

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	hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisiting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to ressit 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 auxillary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complyyying 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 for 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 restructions in area or fire resistance of glass or flames in window assemblies. Findings include: Based on observation on 08/14/23 between 11:56 a.m. and 1:33 p.m. during a tour of the facility with the Maintenance Director, the door to the Janitor Closet next to resident room 212 on the second floor was latched in place while awaiting repair due to the handle falling off. However, the door handle was missing which left a 4 inch penetration through the door. This was acknowledged by the Maintenance Director at the time of observation		**2) How the facility identified other residents:** · Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · The Maintenance Director or Designee will complete monthly visual inspection of doors to ensure proper operation and will document it on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator /designee by 8/23/23. · The Maintenance Director is responsible for compliance. **4)How the corrective actions will be monitored:** · The Administrator will review the Preventative Maintenance Worksheets monthly. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to	

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	and stated parts are on order to fix the door. Findings were discussed with the Maintenance Director and VP of Operations at exit conference. 3.1-19(b)		revise the plan of correction as indicated. **5)Date of compliance: 8/23/23**	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills on each shift for 2 of 4 quarters. LSC 19.7.1.6 states 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. This deficient practice affects all staff and residents. Findings include: Based on records review with the Maintenance Director and the VP of Operations on 08/14/23 between 09:15 a.m. and 11:29 a.m., the following shifts were missing documentation of a completed fire drill: a) A first, second and third shift fire drills in the	K 0712	**K712 NFPA 101 Fire Drill** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is*	08/23/2023

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	first quarter of 2023. b) A first, second and third shift fire drill in the fourth quarter of 2022. Based on interview at the time of record review, the Maintenance Director stated he was unaware if the drills were conducted and stated he had no other documentation to confirm if the fire drills were conducted. Findings were discussed with the Maintenance Director and VP of Operations at exit conference. 3.1-19(b) 3.1-51(c)		*required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified:** · Facility unable to locate Q1-23 and Q4-22 documentation. Fire Drills are currently in compliance. **2) How the facility identified other residents:** · Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · The Maintenance Director or Designee will complete monthly fire drill and will document on Fire Drill Exercise form. · The Maintenance Director is responsible for compliance. **4)How the corrective actions will be monitored:** · The Administrator will review the Fire Drills Log monthly. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance	

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			is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)Date of compliance: 8/23/23**	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable,			

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	and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 5 of 12 months and weekly inspection for 20 of 52 weeks. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Section 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and VP of Operations on 08/14/23 between 09:15 a.m. and 11:27 a.m., no documentation of a weekly visual inspection could be found for between the dates of October 13, 2022 and April 4, 2023. Furthermore, monthly load testing could not be located for the months of November 2022 and February 2023. Based on interview at the time of record review, the Maintenance Director stated that all the	K 0918	**K918 NFPA 101 Electrical Systems- Essential Electric Syste** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified:** · Generator weekly visual inspection and load testing documentation are currently in compliance. **2) How the facility identified other residents:**	08/23/2023

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	documentation that was left from the previous Maintenance Director was in the binder provided and was unable to locate any further documents that could confirm if the inspections and tests had been done. The findings were reviewed with the Maintenance Director and VP of Operations during the exit conference. 3.1-19(b)		· Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · The Maintenance Director or Designee will complete Generator weekly inspection and monthly 30 minutes under load testing and will document on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator /designee by 8/23/23. · The Maintenance Director is responsible for compliance. **4)How the corrective actions will be monitored:** · The Administrator will review the Preventative Maintenance worksheets monthly. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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			5)Date of compliance: 8/23/23	
K 0920 SS=E Bldg. 01	NFPA 101 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 1. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress,	K 0920	**K920 NFPA 101 Electrical Equipment- Power Cords and Extension Cords** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.*	08/23/2023

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	either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect approximately 2 staff. Findings include: Based on observation with the Maintenance Director on 08/14/23 between 11:56 a.m. and 1:33 p.m., in the Medical Records office, a power strip used to power equipment, was not secured, and was dangling by the power cord behind the desk. This condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observations, the Maintenance Director agreed the power strip was dangling, not secured, and stated the power strip will need to be mounted or set on the floor. This finding was reviewed with the Maintenance Director and VP of Operations during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice affect approximately 6 residents and staff. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 08/14/23 between 11:56 a.m. and 1:33 p.m., in the physical therapy gym there was a power strip in use within 6 feet of a resident care area that did not met 1363A or 60601-1. Based on interview at the time of observation, the Maintenance Director agreed a power strip was in use in a resident care area and		*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified:** · Medical Records office power strip was properly mounted. · Physical Therapy room power strip was replace with medical grade. · Extension cord in the janitor closet was removed. **2) How the facility identified other residents:** · Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · The Maintenance Director or Designee will complete visual weekly inspection audit tool to ensure power strips are properly installed and no extension cords	

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	did not meet 1363A or 60601-1. The findings were reviewed with the Maintenance Director and the VP of Operations during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 2 staff and 5 residents in the area. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 08/14/23 between 11:56 a.m. and 1:33 p.m., an extension cord was located in a janitor closet on the North end of the second floor powering a phone charger. Based on interview at the time of observation, the Maintenance Director acknowledged an extension cord was in use. The finding was reviewed with the Maintenance Director and the VP of Operations during the exit conference. 3.1-19(b)		are in use. · All staff will be re-educated in the use of power cords and extension cords. · The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator /designee by 8/23/23. · The Maintenance Director is responsible for compliance. **4)How the corrective actions will be monitored:** · The Administrator will review the Preventative Maintenance worksheets monthly. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)Date of compliance: 8/23/23**	
K 0923 SS=B Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage			

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	Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from 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) Based on observation and interview, the facility	K 0923	**K923 NFPA 101 Gas Equipment-**	08/23/2023

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	failed to ensure 7 of 7 cylinders were segregated from full and empty cylinders and were marked to avoid confusion. NFPA 99, Section 11.6.5.2 states, if empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Section 11.6.5.3 states empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner. This deficient practice could affect up to approximately 5 staff and an unknown number of residents Findings include: Based on observation with the Maintenance Director on 08/14/23 between 11:56 a.m. and 1:33 p.m., the oxygen storage area contained 7 oxygen cylinders that were not marked or separated as full and empty cylinders. Based on interview at the time of observation, the Maintenance Director agreed the oxygen cylinders were not marked as full and empty cylinders and could easily be confused if needed in a rapid manner. This finding was reviewed with the VP of Operations and Maintenance Director at exit conference. 3.1-19(b)		**Cylinder and Container Storage** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified:** · Oxygen room properly marked to identify full and empty cylinders to avoid confusion and ensure proper storage. **2) How the facility identified other residents:** · Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:**	

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			· The Maintenance Director or Designee will complete visual weekly inspection audit tool to Oxygen Cylinders are properly stored. · Nursing staff will be in-service in the proper storage and labeling of Oxygen Cylinders. **4)How the corrective actions will be monitored:** · The Administrator will review the Audit tool Monthly. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)Date of compliance: 8/23/23**	