STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155587	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERFIELD HEALTH CARE	34 S MAIN ST CLOVERDALE, IN 46120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/07/14 Facility Number: 000415 Provider Number: 155587 AIM Number: 100291250 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Summerfield Health Care was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16. This one story fully sprinklered facility with a laundry, maintenance shop, storage room and employee lounge in two separate partial basements was determined to be of Type V (000) construction. The facility has a fire alarm system with hardwired smoke detection	K010000	By submitting the enclosed material we are notadmitting the truth or accuracy of any specific findings or allegations. Wereserve the right to contest the findings or allegations as part of anyproceedings and submit these responses pursuant to our regulatoryobligations. The facility requests thatthe plan of correction be considered our allegation of compliance effectiveSeptember 6, 2014 to the Life Safety Code Survey conducted on August 7,2014. We respectfully request a paper review. We will provide you with any additional informationto confirm compliance per your request	

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

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

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	in the corridors, in spaces open to the corridors, and in resident rooms. The facility has a capacity of 42 and had a census of 39 at the time of this survey. All areas where residents have customary access were sprinklered. All other areas providing facility services were sprinklered except a detached storage building and smoke hut. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/12/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are			

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	permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. 1. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 1 of 5 smoke compartments could automatically latch into the door frame. This deficient practice affects staff, visitors and 10 or more residents on the North wing. Findings include: Based on observation with the maintenance director on 08/07/14 at 1:10 p.m., double doors for the linen closet opening into the north exit corridor were equipped with roller latches which could not secure the doors tightly into the door frame. The maintenance director acknowledged at the time of observation, each door be easily pulled open without disengaging a positive latch. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure corridor doors in 1 of 5 smoke compartments did not have an impediment to closing. This deficient practice affects visitors, staff, and 10 or more residents in the dining room smoke compartment.	K010018	**K018 It is the practice of this facility to assure that doors protecting corridor openings that there will be no impediment to the closing of doors and that doors are provided with a means suitable for keeping the door closed.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** *A new latching devise has been installed on the affected door on the north wing. The door coordinator to the dining room has been adjusted.* ***Other residents that have the potential to be affected have been identified by:*** All residents, visitors and staff had the potential to be affected,but none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Maintenance Director has been re-educated on appropriate latching of doors and on the proper function of the door coordinators. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews the	09/06/2014

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	Findings include: Based on observation with the maintenance director on 08/07/14 at 1:30 p.m., the coordinator attached to the dining room door frame prevented both doors from closing when tested with the maintenance director. The doors, held open by magnets which allowed the doors to close upon activation of the fire alarm system, were again prevented from closing by the door coordinator when the fire alarm was tested. The maintenance director said at the time of the observations, the door coordinator had to be adjusted repeatedly to ensure these doors would close. 3.1-19(b)		latching of doors during maintenance rounds and the proper function of the door coordinators. The Maintenance Director or designee will complete this tool weekly x 3, monthly x 3, and quarterly x 3. Any issues identified will be immediately reviewed and appropriate action taken. The Quality Assurance Committee will review the Performance Improvement Tool at the scheduled meeting. ***The date the systemic changes will be completed: September 6***,2014	
K010021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if			

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	installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure smoke barrier doors in 1 of 5 smoke compartments were held open only by a device which caused the door to close automatically upon activation of the fire alarm system. This deficient practice affects visitors, staff and 10 or more residents in the south smoke compartments. Findings include: Based on observation with the maintenance director on 08/07/14 at 11:30 a.m., the coordinator attached to the door frame of the south smoke barrier doors prevented one door in the south smoke barrier door set from closing when tested with the maintenance director. The door was again prevented from closing by the door coordinator upon activation of the fire alarm system. The maintenance director said at the time of the observations, the door coordinator had to be adjusted repeatedly to ensure these doors would close. 3.1-19(b)	K010021	**K021 It is the practice of this facility to assure that smoke barrier doors in smoke compartments operate properly when the fire alarm system is activated.** ***The correction action taken for those residents found to be affected by the deficient practice include***. A new door coordinator has been installed on the south smoke barrier door. ***Other residents that have the potential to be affected have been identified by:*** All residents, visitors and staff had the potential to be affected, but none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The Maintenance Director has been in-serviced on the importance of the door coordinators to be in proper working order to allow the doors to close when activated by the fire alarm system. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews the proper function of the door coordinators. The Maintenance Director or designee will complete this tool weekly x 3, and monthly x 3, and quarterly x3. Any issues identified will be immediately corrected. The Quality	09/06/2014

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			Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. ***The date the systemic changes will be completed: September 6*, 2014**	
K010029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure doors to hazardous areas, such as a storage rooms larger than 50 square feet, in 1 of 5 smoke compartments closed automatically or upon activation of the fire alarm system. This deficient practice affects visitors, staff and 10 or more residents in the north wing. Findings include: Based on observation with the maintenance director on 08/07/14 at 1:20 p.m., the corridor door to the fourteen by	K010029	**K029 It is the practice of this facility to assure that doors to hazardous areas close automatically.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** A self-closing door closure has been installed on the north wing medical supply storage room. ***Other residents that have the potential to be affected have been identified by:*** All residents, visitors and staff had the potential to be affected, but none were identified. ***The measures or systematic changes that have been put into place to ensure that the***	09/06/2014

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	six foot medical supply storage room on the north wing had no self or automatic closing device. The maintenance director said at the time of observation, he was unaware the 84 square foot room, storage for combustible paper, cardboard and plastic wrapped supplies was required to have a door closer. 3.1-19(b)		***deficient practice does not recur include:*** Maintenance Director has been re-educated on proper self-closing door closures. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly checks doors through out the building for proper door closures. The Maintenance Director or designee will complete this tool weekly x 3, and monthly x 3, and quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. ***The date the systemic changes will be completed: September 6, 2014***	
K010038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 5 of 5 exit doors equipped with magnetic locks were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the	K010038	**K038 It is the practice of this facility to assure that the means of egress through exit doors have the exit code posted.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** *The code for the exit doors has been posted at all exits.* ***Other residents that have the potential to be affected have been identified***	09/06/2014

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	egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice affects all occupants. Findings include: Based on observations with the maintenance director on 08/07/14 between 11:30 a.m. and 1:30 p.m., emergency exit doors were magnetically locked. The maintenance director demonstrated the locks would release by entering a code into a keypad adjacent to the locked doors, however, the code was not posted. The maintenance director said at the time of observations, the facility did not want the residents to "get out." The administrator said during the record review on 08/07/14 at 3:00 p.m., not all residents were considered to have a diagnosis for which locks might be indicated. 3.1-19(b)		***by:*** All residents, visitors and staff had the potential to be affected,but none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All staff have been educated on the posting of the door codes at each door. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that checks for the posting of the exit door codes during walking rounds. The Maintenance Director or designee will complete this tool weekly x 3, monthly x 3, and quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tool. ***The date the systemic changes will becompleted: September 6, 2014***	
K010046	NFPA 101			

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SS=E	LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. 1. Based on observation and interview, the facility failed to ensure the exterior exit discharge path for 1 of 5 emergency exits was provided with emergency powered egress lighting. LSC 7.9.1.1 requires emergency lighting be provided for means of egress, including walkways leading to a public way. This deficient practice affects visitors, staff and 10 or more residents in the dining room. Findings include: Based on observation with the maintenance director on 08/07/14 at 1:45 p.m., the exit discharge path from the dining room included a ninety degree turn to exit to the street evacuation point. The area immediately outside the exit door was not provided with emergency lighting. The maintenance director agreed at the time of observation, the center exit discharge lighting provided could not illuminate the first twelve feet of the exit discharge path. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 16 battery powered emergency lighting fixtures	K010046	K046 **It is the practice of this facility to assure that exterior emergency exits are provided with emergency powered egress lighting and interior emergency lighting is in working order.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** *Exterior emergency egress lighting has been installed outside of the dining room and the interior emergency lighting on the south wing has been replaced*. ***Other residents that have the potential to be affected have been identified by:*** All residents, visitors and staff had the potential to be affected, but none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The Maintenance Director has been educated on on emergency lighting, emergency egress lighting and the importance of proper working light fixtures. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews emergency interior and exterior	09/06/2014

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	would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice affects visitors, staff and 10 or more residents on the south wing. Findings include: Based on observation with the maintenance director on 08/07/14 at 12:35 p.m., the battery powered emergency light fixture provided for the south exit corridor failed to illuminate twice when tested. The maintenance director said at the time of observation, the light was working when checked on 08/01/14. 3.1-19 (b)		lighting during rounds. The Maintenance Director or designee will complete this tool weekly x 3, monthly x 3, and quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tool. ***The date the systemic changes will be completed: September 6, 2014***	
K010056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are			

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	electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure the sprinkler system was installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 5-5.4.2 states deflectors of sprinklers shall be aligned parallel to ceilings, roofs, or the incline of stairs. This deficient practice could affect visitors, staff, and 10 or more residents on the south hall. Findings include: Based on observation with the maintenance director on 08/07/14 at 12:30 p.m., the deflector for the pendant sprinkler head installed in the south soiled utility room alcove was installed on the wall with the deflector perpendicular to the ceiling. The maintenance director acknowledged at the time of observation, this sprinkler head was not installed in the correct orientation. 3.1-19(b) 3.1-19(ff)	K010056	K056 **It is the practice of this facility to assure that the sprinkler system provides complete coverage for all portions of the building.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** *The sprinkler head in the alcove of the south soiled utility room has been replaced with the appropriate deflector sprinkler head.* ***Other residents that have the potential to be affected have been identified by:*** All residents, visitors and staff had the potential to be affected, but none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The Maintenance Director has been educated on on the use of the appropriate deflector sprinkler heads in the facility. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews deflector sprinkler heads in the facility to assure the complete sprinkler coverage if activated. The Maintenance Director or designee will complete this tool weekly x 3, monthly x3, and quarterly x 3. Any issues	09/06/2014

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			identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tool. ***The date the systemic changes will becompleted: September 6, 2014***	
K010062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on observation and interview, the facility failed to ensure piping for 1 of 1 automatic sprinkler systems was maintained free of external loads. NFPA 25, 2-2.2 requires sprinkler piping shall be not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice affects all occupants. Findings include: Based on observation with the maintenance director on 08/07/14 at 2:05 p.m., a sprinkler pipe in the basement mechanical room was used as a hanger to support electrical wiring strung overhead. The sprinkler pipe supplied water from the riser to sprinklers throughout the	K010062	K062 **It is the practice of this facility to assure that piping for the automatic sprinkler system does not have material resting on the pipe or hung from the pipe and that sprinkler heads are free from foreign material and corrosion.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** *The Maintenance Director has removed all electrical wiring from the sprinkler pipe in the basement mechanical room and the sprinkler head has been cleaned.* ***Other residents that have the potential to be affected have been identified by:*** All residents, visitors and staff had the potential to be affected,but none were identified. ***The measures or systematic***	09/06/2014

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NAME OF PROVIDER OR SUPPLIER SUMMERFIELD HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 34 S MAIN ST CLOVERDALE, IN 46120	

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	system. The maintenance director agreed at the time of observation, damage to this pipe, in particular, could affect the water supply to all other sprinklers in the system. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 5 smoke compartments were free of foreign materials, such as paint. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects staff, visitors and 10 or more residents on the south wing. Findings include: Based on observation with the maintenance director on 08/07/14 between 11:30 a.m. and 1:40 p.m., one sprinkler head in the south wing corridor and one in the south wing utility room had paint on them. The maintenance director acknowledged at the time of the observations, the paint was not applied by the manufacturer. 3.1-19(b)		***changes that have been put into place to ensure that the deficient practice does not recur include:*** The Maintenance Director has been educated on on the sprinkler system to be free of external loads as nothing can rest on the pipes and the sprinkler heads must be free of foreign material. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews sprinkler pipes to assure that there are not any wiring hung from the pipes and also review sprinkler heads in the facility to assure their is not any foreign material on the sprinkler head. The Maintenance Director or designee will complete this tool weekly x 3, monthly x 3, and quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tool. ***The date the systemic changes will becompleted: September 6, 2014***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155587	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 08/07/2014
NAME OF PROVIDER OR SUPPLIER SUMMERFIELD HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 34 S MAIN ST CLOVERDALE, IN 46120	

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K010076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure oxygen stored in 1 of 1 sprinklered oxygen storage areas was properly separated from combustibles. NFPA 99, 8-3.1.11.2(c)2 requires the minimal separations from oxygen and combustibles in a sprinklered building be 5 feet. This deficient practice affects staff, visitors and 10 or more residents in the south wing. Findings include: Based on observation with the maintenance director on 08/07/14 at 12:40 p.m., three 181 liter capacity liquid oxygen supply containers and two e-cylinders were stored in a the oxygen supply storage room on the south wing. Plastic covered an oxygen concentrator and two cardboard cartons and a discarded envelope were located less than the minimum five feet permitted between	K010076	***K076* It is the practice of this facility to assure that oxygen storage areas are properly separated from combustibles.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** *The combustible items have been removed from the oxygen supply storage room on the south wing.* ***Other residents that have the potential to be affected have been identified by:*** All residents, visitors and staff had the potential to be affected, but none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All staff and the oxygen delivery vendor have been educated on the guidelines for storage in the oxygen storage room. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A	09/06/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155587	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 08/07/2014
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	combustibles and the stored oxygen containers. The maintenance director acknowledged at the time of observation, the combustibles were too close to the oxygen supply. 3.1-19(b)		Performance Improvement Tool has been initiated that randomly reviews compliance of storage in the oxygen storage room. The Maintenance Director or designee will complete this tool weekly x 3, monthly x 3, and quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tool. ***The date the systemic changes will be completed: September 6, 2014***	